RESPECT–Mil

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BEHAVIORAL HEALTH SPECIALIST MANUAL

THREE COMPONENT MODEL

For Primary Care Management of Depression and PTSD (Military Version)

RESPECT–Mil

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By Thomas E. Oxman, MD, Dartmouth Medical School with contributions from Allen J. Dietrich, MD; John W. Williams, Jr., MD; Charles C. Engel, MD, MPH; Mathew Friedman, MD, PhD; Paula Schnurr, PhD; Stanley Rosenberg, PhD; Sheila L. Barry, RESPECT-Mil Senior Care Manager/Trainer

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DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

U.S. ARMY MEDICAL COMMAND

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I. INTRODUCTION

Behavioral health disorders are common among troops that have returned from war zones. This observation is not new. A report based on health records of Civil War veterans showed life-long health consequences of combat even among those who escaped traumatic injury. Surveys of U.S. combat units returning from the war in Iraq (Hoge, et al, 2004 and 2006) found that as many as one in four Soldiers met criteria for a behavioral health disorder.

Among this group, fewer than one in three had received help from a behavioral health or primary care professional. The stigma of having a behavioral health disorder looms large. While 80 percent of these Soldiers recognized that they had a problem, fewer than half were interested in receiving help.

The gap between need for treatment and receiving it deserves urgent attention. This manual provides one step towards closing this gap by providing background needed for BH Specialists and other behavioral health providers working with primary care clinicians (PCCs) to provide high quality behavioral health care that has a solid evidence base for its effectiveness. Recommendations are consistent with and support application of VA/DoD Clinical Practice Guidelines for Post-Traumatic Stress Disorder (PTSD) and for Depression. This manual is one of a series (PCC, RESPECT-Mil Care Facilitator, BH Specialist) designed as part of a comprehensive depression and post-traumatic stress disorder management system for military primary care settings known as RESPECT-Mil.

The manual describes the RESPECT-Mil program and how to apply the Three Component Model (3CM), a systematic primary care approach to the management of depression. The Three Component Model has been extensively and successfully used in civilian populations (Oxman, et al; Dietrich, et al., 2004). A recent project with the 82nd Airborne Division at Fort Bragg expanded 3CM to address Post-Traumatic Stress Disorder (PTSD) in addition to depression. The project demonstrated that this approach can guide management of depression and PTSD through primary care settings that provide care for troops post-deployment.

Here is how the Three Component Model works:

- Soldiers attending primary care for sick call and who otherwise have a scheduled visit with a PCC are routinely screened for depression (two questions) and PTSD (four questions);
- Those with positive screens complete appropriate diagnostic and severity instruments before seeing the PCC;
- If the instruments suggest that behavioral health issues require exploration and the PCC's diagnostic interview confirms the diagnosis of depression or PTSD, treatment is initiated by the PCC who will continue to follow the patient closely;
- In addition to primary care follow-up visits, Soldiers in treatment are provided with telephone support from a specially trained RESPECT-Mil Care Facilitator, a registered nurse, who promotes adherence to the management plan and monitors response to treatment using validated quantitative instruments. The Care Facilitator communicates routinely and staffs cases with a Behavioral Health Specialist (BH Specialist) who will provide management suggestions communicated in reports from the Care Facilitator to the PCC. The BH Specialist also assists in linking a Soldier to a behavioral health provider when indicated or requested. It is preferable that the BH Specialist be a psychiatrist since the most common management of depression and PTSD in primary care includes medications. If there are local resource challenges, a clinical psychologist or clinical social worker can serve this role with telephone assistance from a BH Specialist.
- Thus, a partnership with the patient is shared among the PCC, a Care Facilitator, and BH Specialist.

This manual describes the RESPECT-Mil conceptual framework and its application first to depression, then to PTSD. For both conditions, use of validated instruments for screening and for symptom assessment are central as are the services of a Care Facilitator, frequent primary care contact, promotion of self-management, and modification of the management plan if needed to achieve improvement in symptoms.

II. CONCEPTUAL FRAMEWORK FOR RESPECT-Mil

This section provides an overview of the concepts upon which the RESPECT-Mil program is based.

Department of Defense Clinical Practice Guidelines

The Department of Defense (DoD), in collaboration with the Veterans Administration, has developed evidence-based clinical practice guidelines (CPGs) for the care of service members. This manual focuses on the application of two of these DoD CPGs—those for major depressive disorder and PTSD. While the DoD CPGs provide a comprehensive overview with a scientific basis for each guideline, this manual focuses on practical application, including a description of new resources available to you as you apply this program with your active duty patients.

Systematic Approaches to Improving Care

We have all been exposed to algorithms that break down a complex task using a series of steps. Such systematic approaches have strong research support for their effectiveness in many fields. One example is the promotion of preventive services. When a medic or other medical assistant checks a patient in and the flow sheet at the front of the chart indicates the patient is not up to date for a certain service, such as an immunization, that service would be provided through standing orders.

Use of systematic approaches has been extended to depression care with demonstrated improved outcomes. These approaches including tools, routines, and clear responsibilities assure that key questions about family and personal history are asked, suicide ideation is explored, evidence-based patient education is provided, and response to treatment is monitored closely. At least twenty (20) randomized controlled trials have shown substantial improvements in depression using systematic approaches. This manual is based on the Three Component Model (3CM®) of depression care, which has been widely applied in civilian populations. This model has now been pilot-tested and shown to be feasible in selected Womack Army Medical Center clinics serving the 82nd Airborne Division at Fort Bragg, North Carolina. The model for the Army is referred to as RESPECT-Mil.

RESPECT-Mil—The Three Components

The three components of the model are clinical roles that consist of the prepared PCC and practice, a trained Care Facilitator, and a BH Specialist. In the RESPECT-Mil model, the PCC is equipped to recognize Soldiers who potentially suffer from depression or PTSD. The PCC then completes a diagnostic assessment including a suicide evaluation, engages the patients in getting help, and provides appropriate management. To aid in this process, new tools and other resources have been developed and are described in Sections III and IV.

Two new resources intended to aid the prepared primary care practice and its PCCs deserve special note. The first new resource is the addition of a trained Care Facilitator, who is a registered nurse. Care Facilitators receive extensive training to help Soldiers suffering from depression and/or PTSD. The Care Facilitator provides frequent contact with the Soldier to answer any questions, encourages the Soldier to stick with the treatment plan, and monitors the Soldier's response to treatment. Care Facilitators work closely with the PCC by communicating in person, by telephone, e-mail, and through the electronic medical record. Care Facilitators typically make the first contact with the Soldier within a week of beginning primary care management for depression or PTSD and then follow up monthly and as needed until remission is reached.

The second new resource, the BH Specialist, participates in the model in several important ways. As noted earlier, the BH Specialist should be a psychiatrist for purposes of providing psychopharmacology and other clinical advice to PCCs. First, he or she meets weekly with the Care Facilitator (in person or by telephone) to discuss specific cases and progress. This staffing provides guidance to the Care Facilitator and presents a mechanism for the BH Specialist to monitor progress on a large number of cases that are being followed in primary care. The BH Specialist is also available to the PCC to provide informal advice about diagnosis and about management. In some cases the PCC, working with the Care Facilitator, will facilitate a direct contact between the patient and the BH Specialist or another behavioral health provider. Table 1 provides an overview of how responsibilities are shared.

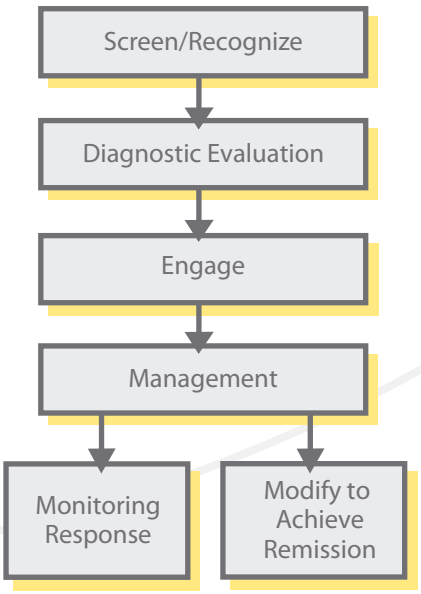
Table 1: RESPECT-Mil:
A Team Working Together to Support the Force

Components	Responsibilities
PCC and Prepared Practice	• Recognition • Diagnosis • Management
Care Facilitator	• Support • Monitoring • Communication
BH Specialist	• Informal advice to PCC • Staff cases with the Care Facilitator(s) • Consultations • Facilitation of specialty care when needed

The RESPECT-Mil Process of Care

An overview of the RESPECT-Mil process is provided in Figure 1 below. The RESPECT-Mil process begins with routine screening for PTSD and major depressive disorder (MDD) when Soldiers come in for sick call and other clinical visits. A validated two-question screen for major depressive disorder and a validated four-question screen for PTSD are completed when the Soldier registers for a visit. Those who screen positive are asked to complete more extensive diagnostic instruments prior to seeing the PCC. These instruments, described in the next sections, do not substitute for the diagnostic interview. Instead, they assure assessment of key diagnostic factors and provide a quantitative baseline assessment of severity of symptoms that can be used to monitor treatment progress.

Figure 1: RESPECT-Mil Process of Care for Depression and PTSD



Informed by screening and diagnostic instrument results, the PCC will then respond to the Soldier's chief complaint as well as to any information suggesting a diagnosis of depression or PTSD. That is, if either diagnosis is suggested, the PCC will explain that additional screening and diagnostic information is appropriate and complete a diagnostic interview. In all cases, this diagnostic interview should include a suicide assessment.

If the patient fits the diagnosis of either PTSD or depression, the PCC will engage the Soldier in an initial course of therapy. This usually begins with determining the appropriate framework for managing the condition—counseling, medication, or a combination of both. At the conclusion of the appointment, the PCC will offer the Soldier suffering from major depressive disorder and/or PTSD the services of a Care Facilitator who will be able to assist the Soldier over time. These Care Facilitator contacts do not substitute for clinical follow-up visits, but rather provide additional contacts to help Soldiers stay the course and achieve a high level of satisfaction, adherence, and response to treatment. In addition, the Care Facilitator performs a valuable and unique role in coordinating communication between the patient, primary care, and the BH Specialist.

The RESPECT-Mil approach to major depressive disorder and PTSD follows a similar structure as illustrated in Table 2.

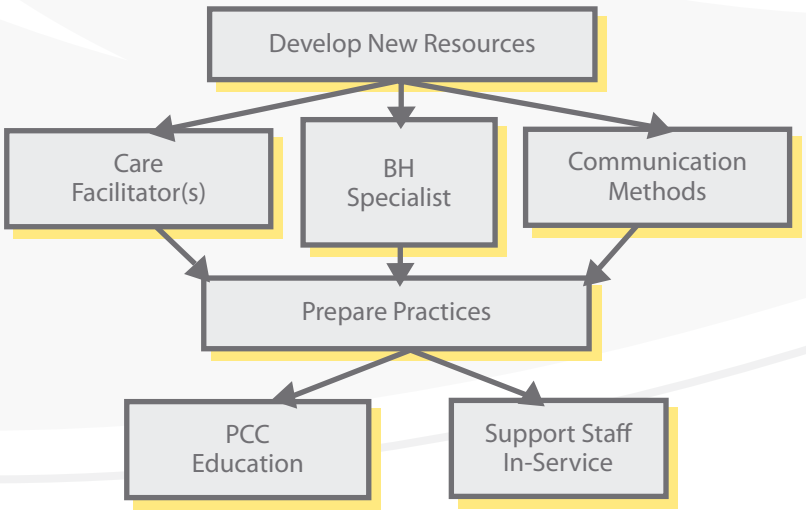
Table 2: RESPECT-Mil Approach to MDD and PTSD

Steps	MDD	PTSD
Screen	2 Questions	4 Questions
Diagnostic Evaluation	PHQ-9 Interview Suicide/violence assessment	PCL Interview Suicide/violence assessment
Engagement	Discuss diagnosis and treatment options	Discuss diagnosis and treatment options
Management	Medications/counseling/both Self-management Care Facilitation BH Specialist advice/support	Medications/counseling/both Self-management Care Facilitation BH Specialist advice/support

RESPECT-Mil Process of Change

Preparing a primary care practice to provide enhanced care for depression and PTSD is the central element of RESPECT-Mil. In addition to the continuing medical education instruction for PCCs, resources including a behavioral health provider, as illustrated in Figure 2, need to be in place for PCCs to provide the best possible care to active duty patients.

Figure 2: Implementing RESPECT-Mil



A Care Facilitator for your clinics(s) will be trained and stands ready to work with you to receive referrals. You should have met, or will be meeting, the Care Facilitator and together will establish a weekly time to meet in person or by telephone. During the initial staffing sessions a centrally located lead BH Specialist from the Center of Excellence will also participate in the telephone calls to assist you in following the staffing reports used to set the agenda, and in establishing an efficient routine. You will receive notice of the agenda before each call. The staffing process is described in more detail in Section V.

In addition, you should introduce yourself to those PCCs whom you do not already know. Offering to be available for curbside consultations is a useful part of the introduction. Usually PCCs do not take sufficient advantage of this to overwhelm your time. However, knowing you are there, they will feel more empowered to attempt management of Soldiers with depression or PTSD that they might not otherwise have considered before.

It is important to be familiar with severity and diagnostic tools. Scores from these instruments are invaluable in monitoring progress and deciding when to make treatment changes. You will be trained in how to use these scores and offer treatment recommendations for the Care Facilitator to communicate to PCCs. Ultimately, the PCC and patient will decide whether to implement your recommendation or not, as primary responsibility remains with them. You will no doubt observe different levels of comfort among PCCs, but as you become more involved in the system, you should experience increased confidence in the PCCs whom you assist in this program.

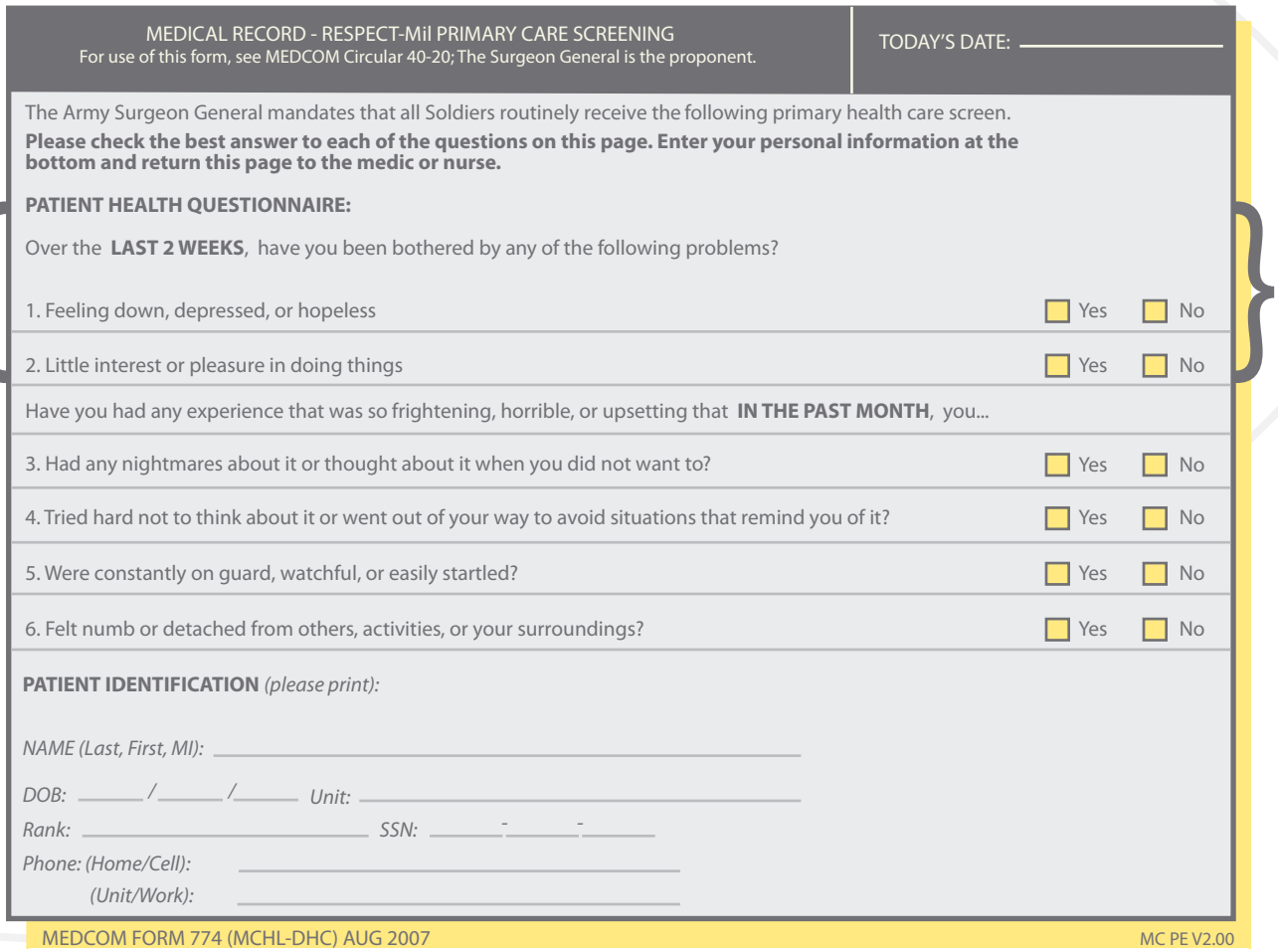
III. RESPECT-Mil PROTOCOL FOR DEPRESSION

This section provides a summary of the instruments and recommended procedures used by PCCs for detection and management of depression. As you will see in Section IV, the framework is quite similar for PTSD.

STEP 1:
Recognition and Diagnosis

RESPECT-Mil routines establish a mechanism for more systematic screening for all patients post-deployment presenting with a new chief complaint. Recognition begins with a two-question screen (see Figure 3) completed by the Soldier. Occasionally, a PCC may suspect a Soldier is depressed, despite responding "no" to the two items on the screen and is encouraged to trust his/her intuition and offer the Soldier the PHQ-9 anyway.

Figure 3: Depression Screening Form (MEDCOM 774) (Two-Question Screen)



MEDICAL RECORD - RESPECT-Mil PRIMARY CARE SCREENING
For use of this form, see MEDCOM Circular 40-20; The Surgeon General is the proponent.

TODAY'S DATE: _____

The Army Surgeon General mandates that all Soldiers routinely receive the following primary health care screen.

Please check the best answer to each of the questions on this page. Enter your personal information at the bottom and return this page to the medic or nurse.

PATIENT HEALTH QUESTIONNAIRE:

Over the **LAST 2 WEEKS**, have you been bothered by any of the following problems?

1. Feeling down, depressed, or hopeless ☐ Yes ☐ No
2. Little interest or pleasure in doing things ☐ Yes ☐ No

Have you had any experience that was so frightening, horrible, or upsetting that **IN THE PAST MONTH**, you...

3. Had any nightmares about it or thought about it when you did not want to? ☐ Yes ☐ No
4. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ☐ Yes ☐ No
5. Were constantly on guard, watchful, or easily startled? ☐ Yes ☐ No
6. Felt numb or detached from others, activities, or your surroundings? ☐ Yes ☐ No

PATIENT IDENTIFICATION *(please print):*

NAME (Last, First, MI): _____

DOB: ____/____/____ *Unit:* _____

Rank: _____ *SSN:* ____-____-____

Phone: (Home/Cell): _____

(Unit/Work): _____

MEDCOM FORM 774 (MCHL-DHC) AUG 2007 MC PE V2.00

PHQ-9

The PHQ-9 is administered to all Soldiers who answer "yes" to either of the two screening questions. The PHQ-9 is a patient self-administered questionnaire that helps make a depression diagnosis and determine severity of depression. The PCC and/or medic/office staff discusses the reasons for completing the questionnaire and explains how to fill it out.

After the patient has completed the PHQ-9 questionnaire, it is scored by the PCC or nursing staff. There are two components to be tallied:

- Assessing the number of symptoms and functional impairment to make a tentative depression diagnosis.
- Deriving a severity score to help select and monitor treatment.

The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the American Psychiatric Association Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

The next few pages will explain how to score and use the PHQ-9. It is important to take time to study how to count symptoms and establish the severity score. During Care Facilitator staffing sessions, the BH Specialist may occasionally have to correct PHQ-9 scores sent by PCCs or reported by Care Facilitators. For example a symptom count of one with a severity score of 12 would not be possible.

Figure 4: Patient Health Questionnaire (PHQ-9)

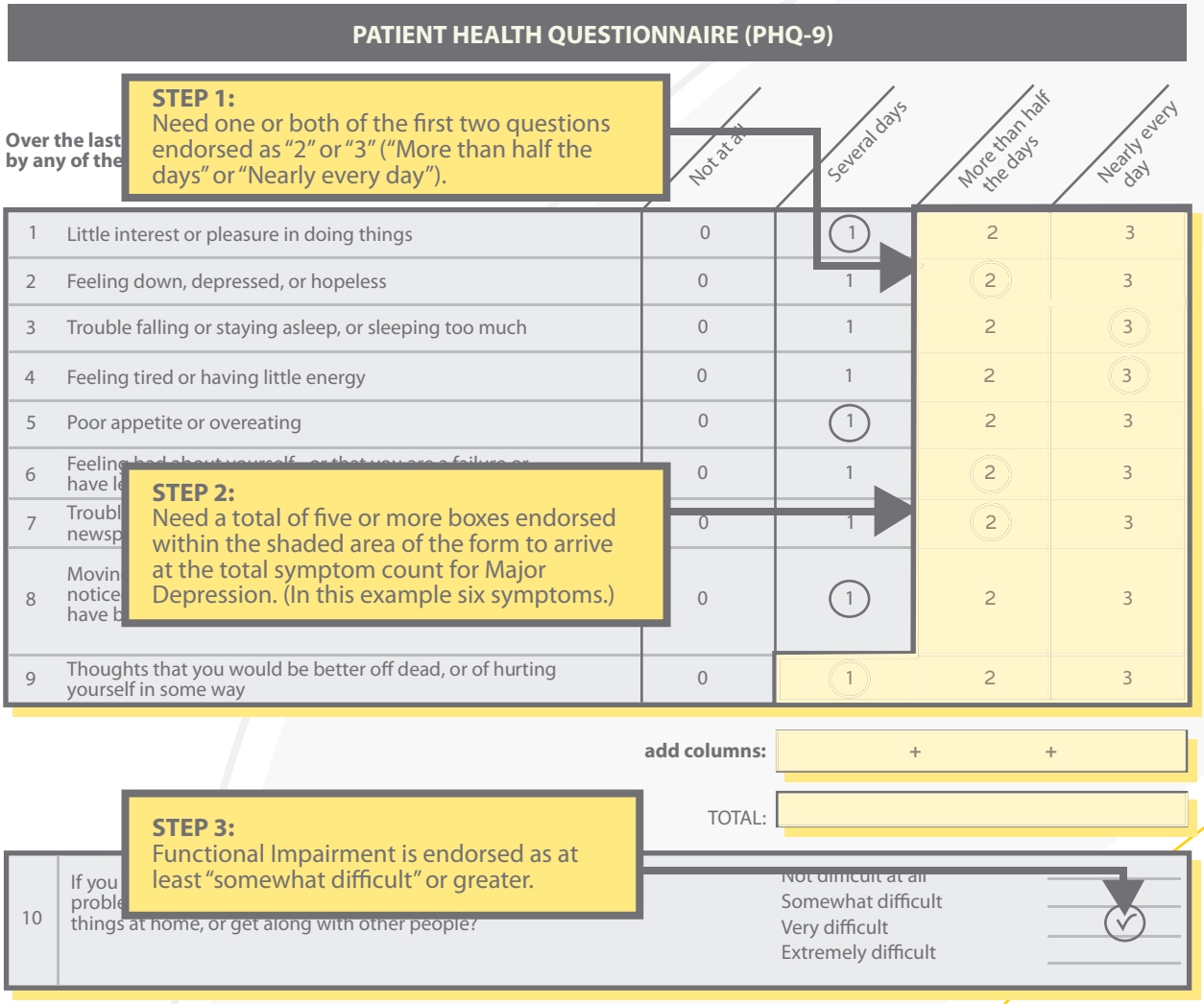
First the number of symptoms and functional impairment endorsed on the PHQ-9 are examined to make a tentative diagnosis of major depressive disorder by looking for three criteria.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

	Over the *last 2 weeks,* how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	(1)	2	3
2	Feeling down, depressed, or hopeless	0	1	(2)	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	(3)
4	Feeling tired or having little energy	0	1	2	(3)
5	Poor appetite or overeating	0	(1)	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	(2)	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	(2)	3
8	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	(1)	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way	0	(1)	2	3
	add columns:		+	+	
	TOTAL:				

10	If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all Somewhat difficult Very difficult Extremely difficult	 ✓

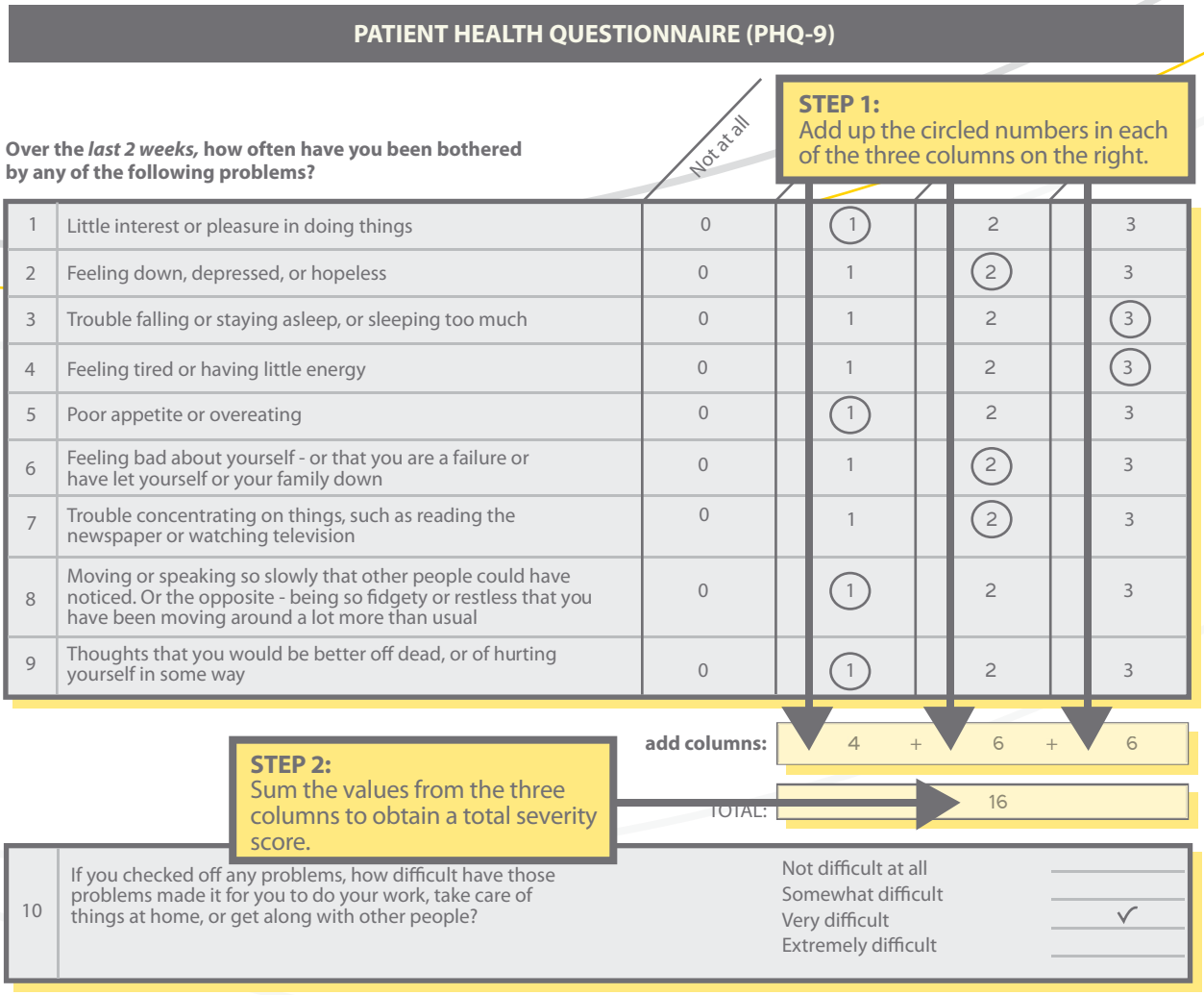
Figure 5: PHQ-9 MDD Diagnosis Example 1



In this example, the criteria for major depressive disorder are met. The second question ("Feeling down, depressed, or hopeless") is endorsed more than half the days, a total of six of the nine symptoms are within the shaded area, and there is functional impairment from the symptoms. Note that for symptoms one through eight, endorsement more than half the days is required. Symptom nine, suicidal thoughts is significant even if endorsed only several days. A positive answer to question nine needs follow-up and will be discussed after computing the PHQ-9 severity score.

Second, a total depression severity score is obtained from the PHQ-9 by summing the values of the endorsed (circled or checked) symptoms. This is most easily done by first adding the values in each of the three columns and then summing the three values. A PHQ-9 severity score can range from zero to 27.

Figure 6: PHQ-9 MDD Diagnosis Example 2



The severity score is extremely useful for helping to determine if and how to treat depression and then to monitor the progress of treatment. First, however, whenever the suicide risk question is positively endorsed, it must be furthered assessed at the time.

Assess Suicide Risk

The Army takes quite seriously the potential for suicide risk in Soldiers. RESPECT-Mil helps to address the risk of suicide post-deployment. Suicidal thoughts are often the symptoms of major depression. For Care Facilitators, and even PCCs, assessment and management of suicidal ideation is an important but often anxiety-provoking task. The following material covers what Care Facilitators are taught about suicide risk, review and management. At moderate to high risk levels of suicidal ideation, telephone referral backup by the lead BH Specialist or other behavioral health provider to the Care Facilitator and PCC is crucial. A major advantage of RESPECT-Mil is in providing systematic assessment guidelines and psychiatric back up.

PCCs and Care Facilitators are taught the following principles. Care Facilitators will always discuss suicidal ideation during weekly staffing sessions and may occasionally contact the BH Specialist for advice or assistance at other times.

Four to six percent of persons with depressive disorders eventually commit suicide. There is no good way to predict in the short term who will commit suicide, although long-term risk is often correlated with the following risk factors:

- Hopelessness
- Prior suicide attempts
- Living alone
- Psychotic symptoms
- Substance abuse
- Male gender (completed suicides)
- Caucasian race
- General medical illnesses

Twenty-five percent of suicide attempts are not premeditated. Suicidality may be an emergent (crisis) or an urgent symptom, but it is always serious.

Conduct a Suicide Assessment

The Care Facilitator always asks patients with depression if they have suicidal thoughts and/or suicidal plans. If they do, the Care Facilitator finds out if they have an active intent (e.g., "I'm going to go home and shoot myself"), or passive intent ("I wish the Lord would take me").

The BH Specialist will be able to view detailed patient responses to suicide risk reviews conducted by the Care Facilitator including her/his recorded actions through RESPECT-Mil's web-based case tracking system, FIRST STEPS. Specific access and training in the use of the system will be provided to designated BH Specialists by the Center of Excellence.

Components of an Evaluation for Suicidal Risk

1. Presence of suicidal or homicidal ideation, intent, or plans.
2. Access to means for suicide and the lethality of those means.
3. Presence of comorbid anxiety disorder, command hallucinations, or severe anxiety.
4. History and seriousness of previous attempts.
5. Family history of, or recent exposure to, suicide.

Emergent

If the patient has an active desire to commit suicide and has no self-control or external supports for safety (e.g. family and friends), then a safe means for transport to the nearest behavioral health clinic or emergency room setting should be found.

Urgent

If a patient has suicidal thoughts without an active plan to commit suicide, it is an urgent situation and could become an emergent one. He/she should get a behavioral health assessment within 48 hours. Patients should know who to contact in a crisis and where to go for emergency help.

Treatment for major depression should begin as soon as it is identified, even if a behavioral health referral has been made, as urgent symptoms may degrade to crisis proportions without it. Prescribe medications that are not deadly in overdose (avoid tricyclics and MAOIs). If anxiety is treated with a benzodiazepine while a patient is suicidal, either have a fellow Soldier or family member dispense it or prescribe it in weekly amounts until the acute risk subsides.

The following tools are available to PCCs and Care Facilitators to help in the evaluation of suicide risk.

Suicide Screening Tools for PCCs

When you make a diagnosis of depression, suicide risk requires assessment. Ask the following, progressive questions. *(Note: The Care Facilitator has a modified suicide review form and should not utilize the version presented here.)*

Table 3: Suicide Screening Questions for Primary Care Clinicians

If question 1 is negative and suspicion is low, the subsequent questions can be skipped.

1. Have these symptoms/feelings we've been talking about led you to think you might be better off dead?
   - ☐ Yes
   - ☐ No

2. This **past week,** have you had any thoughts that life is not worth living or that you'd be better off dead?
   - ☐ Yes
   - ☐ No

3. What about thoughts about hurting or even killing yourself?
   - ☐ Yes ⟹ Go to Question 4
   - ☐ No

4. What have you thought about? Have you actually done anything to hurt yourself?
   - ☐ Yes
   - ☐ No

5. RISK FACTORS FOR SUICIDE:
   - ☐ History of suicide attempt
   - ☐ Social isolation
   - ☐ Substance abuse
   - ☐ Hopelessness
   - ☐ Significant co-morbid anxiety

Table 4: Assessment of Suicide Risk

Description of Patient Symptoms	Level of Risk	Action
No current thoughts. No major risk factors.	**Low Risk**	Continue follow-up visits and monitoring.
Current thoughts, but no plans. With or without risk factors.	**Intermediate Risk**	Assess suicide risk carefully at each visit and contract with patient to call you if suicide thoughts become more prominent. Consult with BH Specialist as needed.
Current thoughts with plans.	**High Risk**	**Emergency BH Referral.**

Figure 7: Care Facilitator Suicide Risk Form

Record Statements in Detail -
Refer to Guidance Notes on Back of Form

Patient Name: _____ PCM: _____ Pt. ID#: _____
Date and Time of Call: _____ RCF Name: _____

1. "In the past month, have you made any plans or considered a method that you might use to harm yourself" (circle one)

YES NO

(If yes, ask, *"Please be specific about these plans or methods you have considered."*)

_____
_____
_____

2. "Have you ever attempted to harm yourself?" (circle one)

YES NO

(If yes, ask, "*When was this? What happened?*")

_____
_____
_____

3. "There's a big difference between having a thought and acting on a thought. Do you think you might actually make an attempt to hurt yourself in the near future?" (circle one)

YES NO

(If yes, ask, "*Can you be specific about how you might do this?*")

_____
_____
_____

4. "In the past month have you told anyone that you were going to commit suicide, or threatened that you might do it?" (circle one)

YES NO

(If yes, ask, "*Who have you told and what have you said to them?*")

_____
_____
_____

5. "Do you think there is any risk that you might hurt yourself before you see your doctor the next time?" (circle one)

YES NO

(If yes, ask, "*What do you think you might do?*")

_____
_____
_____

Action Taken to Contact PCC (Indicate "None" if pt. determined at "Low Risk")

_____
_____

NOTE: All patients with a suicide risk review conducted are to be reviewed with the BH Specialist in a timely manner. This may require immediate contact or may be conducted during staffing depending on level of risk. Only a low risk outcome with no active ideation may wait until the usual staffing session - all others warrant prompt attention.

Guidance Notes for Care Facilitators Regarding Response to Risk Levels

These guidance notes are intended to facilitate the gathering of appropriate information/detail during the conversation and risk review with the patient. That information/detail would then be shared with the PCC and BH Specialist. This should not be considered a basis for decision-making by the Care Facilitator; however, they would guide the action plan to be taken as outlined in the various scenarios below. The FIRST STEPS system will provide immediate indicators to the Care Facilitator regarding the timeline for staffing with the BH Specialist ranging from weekly, to one duty day, to immediate. Local actions regarding 911 should be guided by local Safety SOPs approved by the individual post.

Positive ("YES") Response to Question 5: "Active suicide thoughts: ACUTE RISK"

1. If patient's response is "YES" to question 5, the patient will be considered **"EMERGENT/HIGH SUICIDE RISK."**
2. The Care Facilitator must contact the patient's PCC (or the covering/on-call PCC) immediately to expedite a clinical evaluation. *(If there is on-site behavioral health, this will serve as a primary alternative to PCC assessment. The PCC must still be contacted.)*
3. If the patient presents an obvious acute risk, stay on the phone with the patient, call 911, and/or initiate best actions to ensure that the patient goes immediately to an emergency room.
4. If there is another adult with the patient, then attempt to speak with that person and get assurances that s/he will accompany the patient to an emergency room OR that s/he will dial 911 if they do not have ability or means to transport.
5. Inform the patient's PCC (or on-call PCC) immediately by telephone or direct contact.
6. If the PCC or on-call PCC is not readily available, then the Care Facilitator should next attempt to reach the BH Specialist (or the covering/on-call psychiatrist/BH Specialist).

Positive ("YES") Response to Questions 1-4: "Active suicidal thoughts: MODERATE TO HIGH RISK"

1. If the patient has any positive answer ("YES") to questions 1-4, the patient will be considered "URGENT/MODERATE TO HIGH RISK."
2. This information must be communicated to the patient's PCC (or the covering/on-call PCC) immediately via telephone or direct contact.
3. Patients at this level of risk should be assessed by a qualified BH Specialist within 48 hours.
4. If the PCC or on-call PCC is not readily available, then the Care Facilitator should next attempt to reach the BH Specialist (or the covering/on-call psychiatrist/BH Specialist).

Negative ("NO") responses to Questions 1-4: "Active suicidal thoughts: LOW RISK"

1. If the patient answers "NO" to questions 1-4, the patient will be considered a "LOW SUICIDE RISK." This information should be communicated to the PCC via usual facilitation lines of communication.

STEP 2:
Treatment Selection

Obtain Additional History

Before explaining the diagnosis or recommending a treatment, it may be necessary to learn more about the patient's presenting problem and related symptoms. PCCs are encouraged to ask about the following items; although, they may not always have the time to do so.

- Previous treatment history and response (e.g., history of mania)
- History of response to medication in patient or first-degree relative
- Medications and medical problems
- Patient sensitivity to medications (e.g., anxiety, somatization)
- Psychosocial stressors
- Other psychiatric disorders

Use PHQ-9 Results to Help Determine Treatment Selection

A depression diagnosis that warrants treatment or treatment change, needs **at least one of the first two PHQ-9 questions endorsed as positive** (i.e., little pleasure, feeling depressed) indicating the symptom has been present more than half the time in the past two weeks. In addition, the 10th question about **difficulty** at work or home or getting along with others should be answered at least **"somewhat difficult."** PCCs are instructed to use the following PHQ-9 scoring guideline in recommending treatment selection.

Table 5: Treatment Recommendations

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation
0-4	No depression	N/A
5-9	Minimal symptoms*	Support, educate to call if worse; return in one month.
10-14	Minor depression++ Dysthymia* Major depression, mild	Support, watchful waiting. Antidepressant or psychotherapy. Antidepressant or psychotherapy.
15-19	Major depression, moderately severe	Antidepressant or psychotherapy.
≥20	Major depression, severe	Antidepressant and psychotherapy (especially if not improved on monotherapy).

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask, "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?")

++ If symptoms present ≥ one month or severe functional impairment, consider active treatment.

Present Treatment Options

The PCC presents feasible options for treatment to the patient and describes the pros and cons of each approach. Discussion with the patient should include:

- Side effect profiles for antidepressants available/being considered.
- Availability of psychological counseling.
- Description of psychological counseling.

Elicit Patient Preference for Treatment

Some patients want their PCC to make the decision, but the PCC should ask the patient for their treatment preference.

Choosing Psychological Counseling

PCCs are given the following information to help them describe psychological counseling to Soldiers. (Also see page 50 in the PTSD section regarding Psychological Counseling.)

In psychological counseling, patients with depression work with a BH Specialist (therapist) who listens to them, talks, helps them correct overly negative thinking (which reinforces depressed mood), and improves their relationships with others.

Psychological counseling has been shown to be just as effective as antidepressant medication in treating many people with depression. Psychological counseling can be done individually (the patient and a therapist), in a group (a therapist, the patient, and other patients with similar problems), or it can be family or marriage therapy where a therapist, the patient, and his/her spouse or family members participate. More than half of the people with mild to moderate depression respond well to psychological counseling. While the length of time that persons are involved in counseling differs, people with depression can typically expect to attend a weekly 30 to 60 minute long counseling session for four to 20 weeks. If the patient's depression is not noticeably improved after six to 12 weeks of counseling, this usually means that s/he needs to try a different treatment for his/her depression. Psychological counseling by itself is not recommended as the only treatment for persons whose depression is more chronic or severe. Medication is needed for those types of depression, and it can be taken in combination with psychological counseling.

Psychological counseling is recommended for patients who:

- Prefer psychological counseling.
- Had a previous good response to psychological counseling.
- Cannot tolerate medications.
- Have a prior course of illness that is chronic or characterized by poor inter-episode recovery.

For patients who are taking antidepressants, other types of psychological counseling may also be helpful and should be recommended for patients who:

- Have partial response to full dose of an antidepressant;
- Have personality disorders; and/or
- Have complex psychosocial problems.

Choosing Medication

PCCs are also given the following information regarding selection of antidepressants.

Antidepressants are effective for depression treatment. Many antidepressants are available and there is no evidence that any one is better than another. The major differences are the side effects and cost/availability.

A reference table is inserted in this manual and lists the dosing, advantages and disadvantages of the various antidepressants available.

Antidepressant*	Therapeutic Dose Range (mg/day)	Initial Suggested Dose	Titration Schedule**	Advantages	Disadvantages
Serotonin Reuptake Inhibitors (SSRIs)					
Citalopram (Celexa)	20 - 40	20 mg in morning with food (10 mg in elderly or those with panic disorder).	Maintain 20 mg for 4 weeks before dose increase. If no response, increase in 10 mg increments every 7 days as tolerated.	Probably helpful for anxiety disorders. Possibly fewer cytochrome P450 interactions. Generic.	
Escitalopram (Lexapro)	10 - 20	10 mg for escitalopram.	Increase to 20 mg if inadequate response after 4 weeks.	s-enantiomer more potent than racemic, 10 mg dose often effective. Generic available. Reduces all three symptom groups of PTSD.	
Fluoxetine (Prozac)	10 - 80	20 mg in morning with food (10 mg in elderly and those with comorbid panic disorder).	Maintain 20 mg for 4-6 weeks and 30 mg for 2-4 weeks before dose increases. Increase in 10-20 mg increments at intervals of 7 days. If significant side effects occur within 7 days, lower dose or change medication.	Helpful for anxiety disorders. Long half-life good for poor adherence, missed doses. Generic available. Less frequent discontinuation symptoms. Reduces all 3 PTSD symptom groups.	Slower to reach steady state. Sometimes too stimulating. Possibly more cytochrome P450 interactions.
Paroxetine (Paxil)	10 - 50 (40 in elderly)	20 mg once daily, usually in morning with food (10mg in elderly and those with comorbid panic disorder).	Maintain 20 mg for 4 weeks before dose increase. Increase in 10 mg increments at intervals of approximately 7 days up to a maximum of 50 mg/day.	FDA approved for most anxiety disorders. Generic soon. Reduces all three symptom groups of PTSD.	Sometimes sedating. Occasionally more anticholinergic-like effects. Possibly more cytochrome P450 interactions. Maybe have more frequent discontinuation symptoms.
Paxil (CR)	25 - 62.5 (50 in elderly)	25 mg daily (12.5 mg in elderly and those with panic disorder).	Increase by 12.5 mg at weekly intervals. Maintain 25 mg for 4 weeks before dose increase.	May cause less nausea and GI distress.	
Sertraline (Zoloft)	25 - 200	50 mg once daily, usually in morning with food (25 mg for elderly).	Maintain 50 mg for 4 weeks. Increase in 25-50 mg increments at intervals of 7 days as tolerated. Maintain 100 mg for 4 weeks before next dose increase.	FDA approved for anxiety disorders including PTSD. Safety shown post MI.	
Serotonin and Norepinephrine Antagonist					
Mirtazapine (Remeron)	15 - 45	15 mg at bedtime (7.5 mg for those in need of sedation/hypnotic).	Increase in 15 mg increments (7.5 mg in elderly) as tolerated. Maintain 30 mg for 4 weeks before further dose increase.	Few drug interactions. Less or no sexual dysfunction. Less sedation as dose increased. May stimulate appetite. Generic. May reduce all three symptom groups of PTSD.	Sedation at low dose only. May initially stimulate appetite.

Antidepressant*	Therapeutic Dose Range (mg/day)	Initial Suggested Dose	Titration Schedule**	Advantages	Disadvantages
Norepinephrine and Dopamine-Reuptake Inhibitor					
Bupropion◆ (Wellbutrin SR, Wellbutrin XL)	300 - 400	150 mg in the morning.	Increase to 150 mg bid after 7 days. Increase to 200 mg bid if insufficent response after 4 weeks. 8 hours between doses and initially not at bedtime. With hepatic disease only 100 mg total per day.	Stimulating. Less or no sexual dysfunction. Generic available. May reduce all three symptom groups of PTSD.	At higher dose, may induce seizures in persons with seizure disorder. Stimulating. Usually b.i.d. dosing, unless more expensive XL.
Serotonin and Norepinephrine Reuptake Inhibitor					
Duloxetine (Cymbalta)	40 - 120	40 to 60 mg per day in single or bid dose as tolerated.	Norephinephrine effect occurs at 60mg and higher. 60mg adequate target dose. Up to 120 mg has been used but no clinical advantage demonstrated.	Also approved for diabetic peripheral neuropathic pain. Used for stress urinary incontinence.	May increase blood pressure. bid dosing. Nausea. Avoid in any hepatic impairment or severe renal failure.
Venlafaxine (Effexor, Effexor XR)	75 - 375	75 mg with food; if anxious or debilitated, 37.5 mg.	Dose should be divided bid or tid unless XR. For extended release (XR) give 37.5 in am after 1 week, 150 mg in the am after 2 weeks. If partial response after four weeks increase to 225 mg in the morning. Norepinephrine effect only occurs above 150 mg.	XR version can be taken qd. Helpful for anxiety disorders. Possibly fewer cytochrome P450 interactions. May reduce all three symptom groups of PTSD.	May increase blood pressure at higher doses. Bid dosing unless use XR. Expensive. More lethal in overdose (with other drugs & alcohol) than SSRIS but not TCAs.
Primarily Norepinephrine Reuptake Inhibitor					
Desipramine◆◆ (Norpramin, Pertofrane)	100 - 300 (25-100 in elderly)	50 mg in the morning.	Increase by 25 to 50 mg every 3 to 7 days to initial target of 150 mg for 4 weeks.	More effect on norepinephrine than serotonin, less sedating. Generic available. Reduces avoidance/numbing symptom group of PTSD.	Like all TCAs, anticholinergic. Caution with BPH. **Can exacerbate cardiac conduction problems or CHF.**
Nortriptyline◆◆ (Aventyl, Pamelor)	25- 150	25 mg (10 mg in frail elderly) in the evening.	Increase in 10-25 mg increments every 5 days as tolerated to 75 mg. Dosing too high may be ineffective. Obtain serum drug levels after 4 weeks if not effective.	Availability of reliable, valid blood levels. Lower orthostatic hypotension than other tricyclics. Generic available. Probably reduces avoidance/numbing symptom group of PTSD.	Like all TCAs, anticholinergic. Caution with BPH. **Can exacerbate cardiac conduction problems or CHF.**

*There are more antidepressants than those listed in this table; however, as of JANUARY 2007 this list provides a reasonable variety of drugs that have different side effects and act by different neurotransmitter mechanisms. Clinicians should check for updates via evidence based sources. Treatment of Parkinson's disease may include selegline (Eldepryl), which is a selective monoamine oxidase inhibitor at low doses only. Because the use of many antidepressants is contraindicated in conjunction with a nonselective MAOI, caution with or discontinuation of Eldepryl may be in order. For pregnancy, TCAs and SSRIs (particularly fluoxetine, because of more data collected) are not associated with congenital malformations or developmental delay. SSRIs in the third trimester are associated with a slight decrease in gestational age and correspondingly lower weight, and occasionally with neonatal withdrawal symptoms. Diarrhea, drowsiness, and irritability are occasionally seen in breast fed infants of mothers taking antidepressants. The risks of maternal depression on child development should be balanced against the effects of antidepressants on an individual basis.

**For SSRIs, generally start at the beginning of therapeutic range. If side effects are bothersome, reduce doses and increase slower. In debilitated or those sensitive to medications, start lower. For all antidepressants, allow four weeks at a therapeutic dose, assess for a response. If a partial or slight response, then increase dose. If no response or worse symptoms then consider switching drugs.

◆ Generally avoid bupropion in patients with a history of seizures, significant central nervous system lesions, or recent head trauma.

◆◆Tricyclic antidepressants (TCAs) have lower costs but somewhat higher discontinuation rates compared to SSRIs due to side effects and are more lethal in overdose. TCAs may be contraindicated in patients with certain physical comorbidities such as recent myocardial infarction, cardiac conduction defects, urinary retention, narrow angle glaucoma, orthostatic hypotension, and cognitive impairment.

STEP 3:
Initiating Treatment

Patient Engagement

Educating patients about depression and treatment options often encourages them to become partners in their care process. The next step is to provide more specific engagement around the agreed upon treatment.

Provide Key Educational Messages

PCCs and Care Facilitators are instructed to provide the following key messages to patients starting antidepressant medication *(available as a patient education handout):*

Table 6: Advice to Patients Commencing Antidepressant Therapy - Key Educational Messages

- Antidepressants only work if taken every day.
- Antidepressants are not addictive.
- Benefits from medication appear slowly.
- Continue antidepressants even after you feel better.
- Mild side effects are common and usually improve with time.
- If you are thinking about stopping the medication, call me first.
- The goal of treatment is complete remission. Sometimes it takes a few tries.

For patients starting psychological counseling, Care Facilitators and PCCs are instructed to provide these instructions:

- Counseling takes a little longer before you will feel any improvements.
- Keep your appointments with the therapist.
- Be honest and open, and ask questions.
- Work cooperatively with the therapist (e.g., complete tasks assigned to you as part of the therapy).
- If you have problems or are not satisfied with your therapist, call us and we'll help you.

Tell all patients:

- If you are feeling worse, don't wait until your next appointment.
- Call my office right away!

Encourage a Self-Management Plan

PCCs are taught to offer self-management to all Soldiers being treated for depression in primary care. In practice, Care Facilitators are more likely to have the time and be the ones to discuss specifics of self-management. During Care Facilitator staffing, adherence to and discussion of self-management plans should be discussed. Care Facilitators will encourage

Soldiers to select a small, achievable goal to work on each week for the next several weeks. Selecting a self-management plan is an activity to reinforce positive coping and help alleviate some symptoms while waiting for the effects of medication. In addition, self-management can promote the patient's confidence and activation both of which are associated with improved behavioral health outcomes. Goals should be simple with small increments to begin with and can include the following.

Figure 8: Self-Management Worksheet

There are a number of things you can do to help yourself feel better when you're not at your best. We suggest you select one activity here that you can start on. Remember to take it slowly at first and add new things as you begin to feel better.

1. Make time for pleasurable physical activity.
Make sure you make time to address your basic physical needs, for example, walking for a certain amount of time each day.

Every day next week, I will spend at least _____ minutes (make it easy, reasonable) doing:
_____

2. Make time for pleasurable activities.
Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some fun activity each day, maybe a favorite hobby.

Every day next week, I will spend at least _____ minutes (make it easy, reasonable) doing:
_____

3. Spend time with people who can support you.
It's easy to avoid contact with people when you're down or not at your best, but you need the support of friends and family. Explain to them what you are experiencing, if you can. If you can't talk about it, **that's okay.** Just asking them to be with you, maybe during one of your activities, is a good first step.

During the next week, I will make contact for at least _____ minutes (make it easy, reasonable) with (name) doing/talking about:
_____

4. Practice relaxing.
For many people, the changes that come with depression can lead to anxiety. Some physical relaxation can lead to mental relaxation. Practicing relaxing is another way to help yourself. Try deep breathing, taking a warm bath, or just find a quiet, comfortable, peaceful place and say comforting things to yourself (like, "It's okay").

Every day next week, I will practice physical relaxation at least _____ times, for at least _____ minutes each time (make it easy, reasonable).

5. Simple goals and small steps.
It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others cannot. It can be hard to deal with them when you're feeling sad, have little energy and are not thinking as clearly as usual. Try breaking things down into small steps. Give yourself credit for each step you accomplish.

The problem is _____
My goal is _____
Step 1: _____
Step 2: _____
Step 3: _____

6. Eat nutritious, balanced meals.
You are what you eat. Many people find that when they eat more nutritious, balanced meals, they not only feel better physically, they feel better emotionally and mentally also.

During the next week, I will improve my diet by:
_____
(Example: "Strive for five." Eat at least five fruits and vegetables a day.)

7. Avoid alcohol.
Alcohol is a depressant and can add to feeling down and alone. It can also interfere with the help you may receive from antidepressant medication.

I will restrict my alcohol intake to no more than two drinks on no more than two days per week.

PCCs Explain and Recommend Care Facilitation

Explain the role of the Care Facilitator as a systematic extension of the PCC's ability to monitor treatment response and side effects as well as to assist the patient in maintaining or adjusting self-management goals.

- The Care Facilitator calls in one week to be sure treatment has started or to help solve problems if it has not.
- The Care Facilitator generally calls at subsequent four-week intervals to re-administer the PHQ-9 to review effects of treatment.
- Verifying the best available phone number for the patient will facilitate an easy initial contact by the Care Facilitator.
- Let the patient know typical Care Facilitator contact intervals and that follow-up office appointments will help in treatment.

PCCs then complete and transmit a Referral to the Care Facilitator via CHCS I/AHLTA including relevant details as demonstrated in Figure 9.

Figure 9: Referral to Care Facilitator (CHCS I / AHLTA)

View Referral

Patient: XXXXX, PVT FMP/SSN: xxxxxxxxx

Pt. SSN: xxxxxxxx Sex/DOB/Age: 22 y

Reason for Referral:

22 year old male screened positive for depression with **PHQ-9 results of 6 symptoms and score of 16**

Pt. elected to start a **fluoxetine 20 mg** and will be returning to clinic in 1 month

Pt. selects swimming as a self-management goal and will start at 1x per week

Pt. agrees to RESPECT-Mil Care Facilitator support/requests call

Home phone # preferred and verified

STEP 4:
The Facilitation Process

Functions of the Care Facilitator

Care Facilitators are trained to help patients follow through with treatment plans developed by their PCC. With the goal of remission in mind, the functions of the Care Facilitator are to:

1. Monitor adherence to the treatment plan.
2. Support adherence to the treatment plan.
3. Monitor treatment response.
4. Routinely communicate this information to the PCC and BH Specialist.

The BH Specialist provides advice on all four functions when indicated. When a Care Facilitator and BH Specialist first start implementing the three components of RESPECT-Mil, it is worthwhile to discuss all four functions with most patients as they occur during the staffing process. Over time, more staffing time will be spent on monitoring treatment response, making treatment recommendations, and determining how to best communicate recommendations to the PCC.

Adherence Call at One Week

- Care Facilitator calls one week after initial visit.
- If prescribed antidepressants, confirms that patient has filled prescription and started medication.
- Care Facilitator inquires about side effects and problem solves with patient.
- If the patient was referred to psychological counseling, Care Facilitator confirms that appointment was made and kept or there is an intention to keep.
- If medication has not started or psychological counseling appointment has not occurred, further adherence calls planned.
- Care Facilitator discusses benefits of self-management and assists Soldier in selecting an initial goal, starting with small and simple steps.
- Care Facilitator will mail educational materials if they were not obtained at the time of the office visit.

Optional Telephone Contacts Between One and Four Weeks: Additional Adherence Call(s)

- If medication is being titrated upward, asks if dose has been increased and if there are any side effects.
- If behavioral health referral, asks if first visit has been completed.
- Inquires about and encourages self-management activity.
- Helps Soldier problem solve regarding the areas noted above.

Barriers to Adherence and Barrier Problem Solving

Once a barrier has been identified, the Care Facilitator will help the patient set a reasonable goal that will lead to adherence to the treatment plan. For example, for the first week, if a patient has been prescribed a medication and has not gotten the prescription filled, this would be a primary barrier to focus on in the first call. The goal for this particular patient would be to get the prescription filled in the next few days to a week. If the patient indicates a willingness to follow through, then the Care Facilitator would also seek to obtain the patient's agreement to actually start taking the medication. The Care Facilitator and the patient should come to an agreement of what a reasonable time interval will be to fill the prescription and start taking it. S/he should then set up a time for the next call to check in on the patient's progress in completing these steps towards treatment. If the patient does not then follow through and start the medication, the PCC should be notified. Care Facilitators frequently must brainstorm with patients about the various ways to achieve goals and facilitate adherence to the treatment plan. The Care Facilitator should encourage the patient to think of ways to achieve treatment goals that might be different from his/her usual ways of coping.

Soldiers with depression or PTSD need positive feedback for even the smallest of steps taken toward reaching their goals. The process of improving is an iterative one, with the first small step providing the foundation for the next step.

Treatment Response Calls Every Four Weeks

- Care Facilitator contacts are intended to occur at least every four weeks. Patient response to the PHQ-9 is obtained every four weeks in order to provide the BH Specialist with objective symptom monitoring, to advise the PCC on any necessary treatment changes, and to determine when remission occurs.
- Changes in PHQ-9 severity are reviewed and reported to the PCC and the BH Specialist.
- Care Facilitator staffing sessions for the review of patient progress are conducted by the BH Specialist and information/concerns conveyed to the PCC by the Care Facilitator.

Care Facilitation Staffing

Care Facilitators have weekly staffing sessions with you (and other BH Specialists if involved) to review adherence problems, side effects, and sub-optimal responses. These sessions generally last an hour or less.

Communication with the PCC

- Care Facilitator and PCC communicate via e-mail and/or AHLTA after care facilitation contacts and office visits.
- BH Specialist and PCC communicate by phone, e-mail, and/or in person on selected cases.

Below is an example of a follow-up PHQ-9 obtained by a Care Facilitator after four weeks of antidepressant treatment at an initial adequate dose. At this point, the severity score and functional impairment are the primary pieces of information needed to monitor treatment response. Normally the Care Facilitator will have scored the PHQ-9 and provided you with the score and the difference in severity score from baseline. To be sure you understand how to score the PHQ-9, score the following PHQ-9 for severity.

Figure 10: PHQ-9 Follow-Up for Depression Scoring

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

	Over the *last 2 weeks,* how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	(2)	3
2	Feeling down, depressed, or hopeless	0	1	(2)	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	(3)
4	Feeling tired or having little energy	0	1	2	(3)
5	Poor appetite or overeating	(0)	1	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	(2)	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	(2)	3
8	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	(0)	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way	(0)	1	2	3
	add columns:		+	+	
	TOTAL:				

10	If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all Somewhat difficult Very difficult Extremely difficult	 ✓

Figure 11: Care Facilitator Report to PCC (AHLTA)

MailMan message for: Dr. XXXXX

Subj: XX/XXX-X/X-XXXX - **Telephone Consult**

From: POSTMASTER (Sender: RESPECT-Mil Care Facilitator)

Telephone Consultation

Provider's Note:

S: This 22 year old Soldier seen and referred on 29 March 2005 with a PHQ-9 score of 16 and started on fluoxetine 20 mg same date. Pt. set a goal of swimming 1x per week and has completed his goal each week. He has increased goal for next month to 2x per week.

PHQ-9 re-administered over phone this date (week 4 of Tx). Score is now 14 (0 on suicide question). Minimal decrease in score or symptoms. Pt. reports nausea but willing to continue Rx. Advised to take Rx with food.

Dr. YYYYY (BH Specialist) suggests increasing dose to 40 mg at this time and monitoring nausea.

Care Facilitator will call again in one week to monitor.

Provider: **RESPECT-Mil Care Facilitator**

Using the PHQ-9 to Monitor Patient Response to Treatment

The goal of acute phase treatment is remission of symptoms as indicated by a PHQ-9 score of < 5 points. Patients who achieve this goal enter into the continuation phase of treatment. Patients who do not achieve this goal remain in the acute phase of treatment and require some alteration in treatment (dose increase, medication change, augmentation, combined antidepressant/psychological counseling). Patients who do not achieve remission after two adequate trials of antidepressants and/or psychological counseling for 20 to 30 weeks would benefit from a formal or informal psychiatric consultation for diagnostic and management suggestions.

Table 7: Assessment of Patient Response to Treatment

Initial Response After Six to Eight weeks of Adequate Dose of Antidepressant		
PHQ-9 Score	**Treatment Response**	**Treatment Plan**
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Follow-up in four weeks.
Drop of 3 – 4 points from baseline	Probably Inadequate	Often warrants an increase in antidepressant dose.
Drop of 1 – 2 points or no change or increase	Inadequate	Increase dose; Augmentation; Switch; Informal or formal psychiatric consulation; Add psychological counseling (especially if not improved with monotherapy).
Initial Response to Psychological Counseling After Three Sessions over Four to Six Weeks		
PHQ-9 Score	**Treatment Response**	**Treatment Plan**
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Care Facilitator follow-up in four weeks.
Drop of 3 – 4 points from baseline	Probably Inadequate	Possibly no treatment change needed. Share PHQ-9 with psychological counselor.
Drop of 1 – 2 points or no change or increase	Inadequate	If depression-specific psychological counseling (CBT, PST, IPT) discuss with therapist, consider adding antidepressant. For patients satisfied in other type of psychological counseling, consider starting antidepressant. For patients dissatisfied in other psychological counseling, review treatment options and preferences.

Antidepressant Side Effects

Side effects account for as many as two-thirds of all premature discontinuations of antidepressants. Most side effects are early onset and time limited (e.g., SSRI decreased appetite, nausea, diarrhea, agitation, anxiety, and headache). These can be managed by temporary aids to tolerance. Some side effects are early-onset and persistent or late onset (e.g., SSRI apathy, fatigue, weight gain, sexual dysfunction) and may require additional medications or a switch to another antidepressant.

Strategies for managing antidepressant side effects:

1. Allow patient to verbalize his/her complaints about side effects.
2. Wait and support. Some side effects (i.e., GI distress) will subside over one to two weeks.
3. Lower the dose temporarily.
4. Treat the side effects (see below).
5. Change to a different antidepressant.
6. Discontinue medications and start psychological counseling.

Table 8: Common Side Effects of Antidepressants

SIDE EFFECT	SSRIs VENLAFAXINE	TRICYCLICs (nortriptyline, amitriptyline, imipramine)	BUPROPION	MIRTAZAPINE	MANAGEMENT STRATEGY
Sedation	+/-	++	-	+	* Give medication at bedtime. * Increase mirtazapine dose. * Try caffeine.
Anticholinergic-like symptoms. Dry mouth/eyes, Constipation, Urinary retention, Tachycardia	+/-	+++	-	+/-	* Increase hydration. * Sugarless gum/candy. * Dietary fiber. * Artificial tears. * Consider switching medication.
GI distress Nausea	++	-	+	+/-	* Often improves in 1-2 weeks. * Take with meals. * Consider antacids or H2 blockers.
Restlessness, Jitters/Tremors	+	+/-	++	-	* Start with small doses, especially with anxiety disorder. * Reduce dose temporarily. * Add beta blocker (propranolol 10-20 mg bid/tid). * Consider short trial of benzodiazepine.
Headache	+	-	+	-	* Lower dose. * Acetaminophen.
Insomnia	+	-	+	-	* Trazodone 25-100 mg po qhs (can cause orthostatic hypotension and priapism). * Take medication in am
Sexual dysfunction	++	-	-	-	* May be part of depression or medical disorders. * Decrease dose. * Try adding bupropion 100 mg qhs or bid. * Try adding buspirone 10-20 mg bid/tid. * Try adding cyproheptadine 4 mg 1-2 hrs before sex. * Consider a trial of Viagra.
Seizures	-	-	+	+/-	* Discontinue antidepressant.
Weight gain	+/-	+/-	+/-	+/+	* Exercise. * Diet. * Consider changing medications.

KEY: - Very Unlikely +/- Uncommon + Mild ++Moderate

STEP 5:
Acute Phase Follow-up

PCC Office Visits Coordinated with Facilitation Contacts

Primary care office visits should typically occur after you and the Care Facilitator have reviewed any changes in PHQ-9 scores. Figure 13 shows the "typical" timing of Care Facilitator contacts. However, RESPECT-Mil does not prescribe the timing of contacts because of the wide variation in patient and PCC schedules.

Evaluate Patient Response to Treatment

For antidepressants, a measurable, partial response to adequate dose usually occurs by four weeks. A remission of symptoms usually occurs by eight to 12 weeks.

For psychological counseling, initial response may take somewhat longer and remission depends on severity of psychosocial stressors.

- Review symptoms, PHQ-9 score, and functional review provided by Care Facilitator from earlier phone call.

Modify Treatment with Sub-Optimal Response

Decisions to continue or modify treatment (typically at four week intervals) are made on the basis of PHQ-9 reviews.

Input from BH Specialist can be requested at any time or may be offered when indicated after review with Care Facilitator.

Strive for Remission

The goal of acute phase treatment is to achieve remission. Monitor treatment response and modify periodically so that patients will have:

A reduction of the PHQ-9 to a score < 5 points and NO functional impairment

When patients achieve this goal they enter into the continuation phase of treatment. Patients who do not achieve this goal remain in acute phase treatment and require some alteration in treatment (dose increase, augmentation, combination treatment). Patients continue with facilitation follow-up periodically and see their PCC as needed.

Figure 12: PCC Reassessment

MailMan message for RESPECT-Mil Care Facilitator

Subj: XX/XXX-X/X-XXXX - **Telephone Consult**

From: POSTMASTER (Sender: Dr. XXXXX)

Telephone Consultation

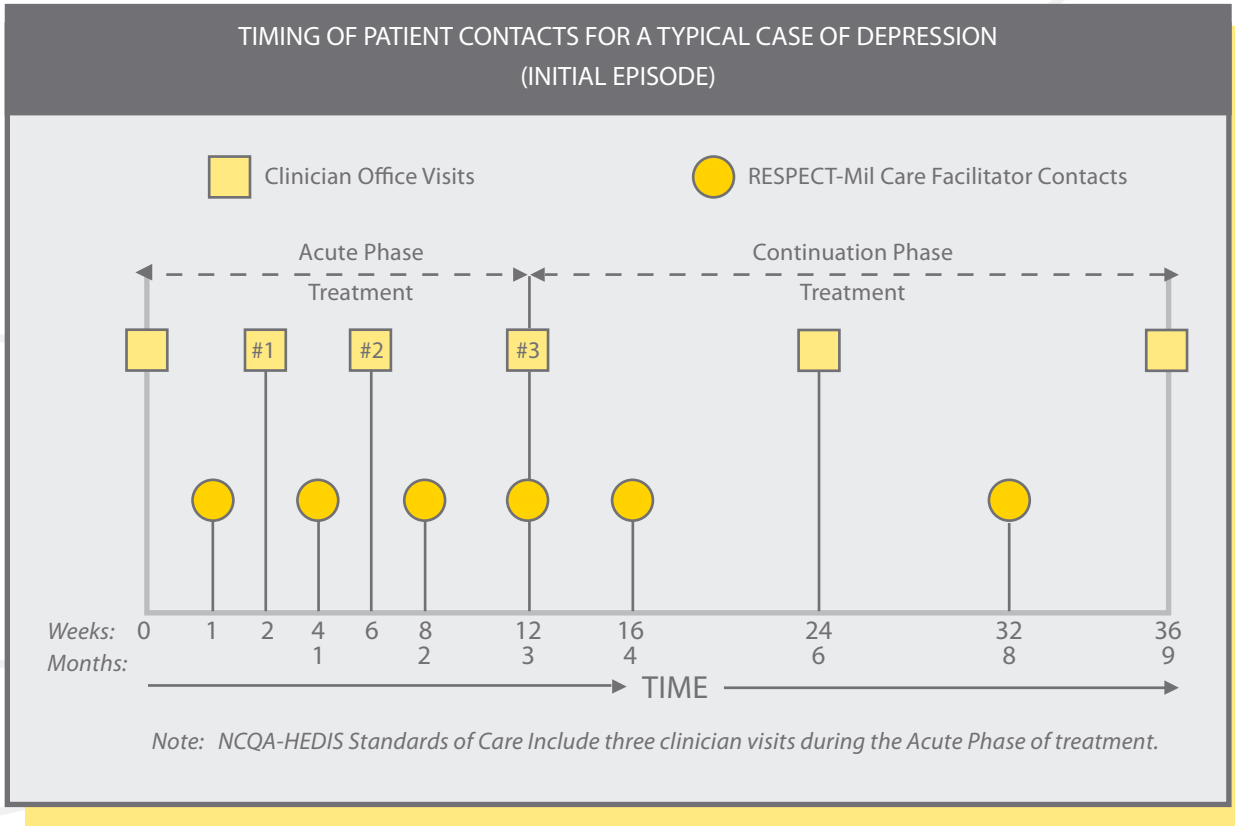
Provider's Note
S: 22 year old Soldier with depression. Initial treatment with fluoxetine 20 mg resulting in minimal improvement per PHQ-9 reviewed by Care Facilitator. Spoke today with patient.

IMP/PLAN: Inadequate treatment response. Will increase fluoxentine to 40 mg.

Request that Care Facilitator call in 1 week, verify pt. increased Rx. RTC 4 weeks.

Provider: Dr. XXXXX

Figure 13: Typical Frequency of Patient Contacts

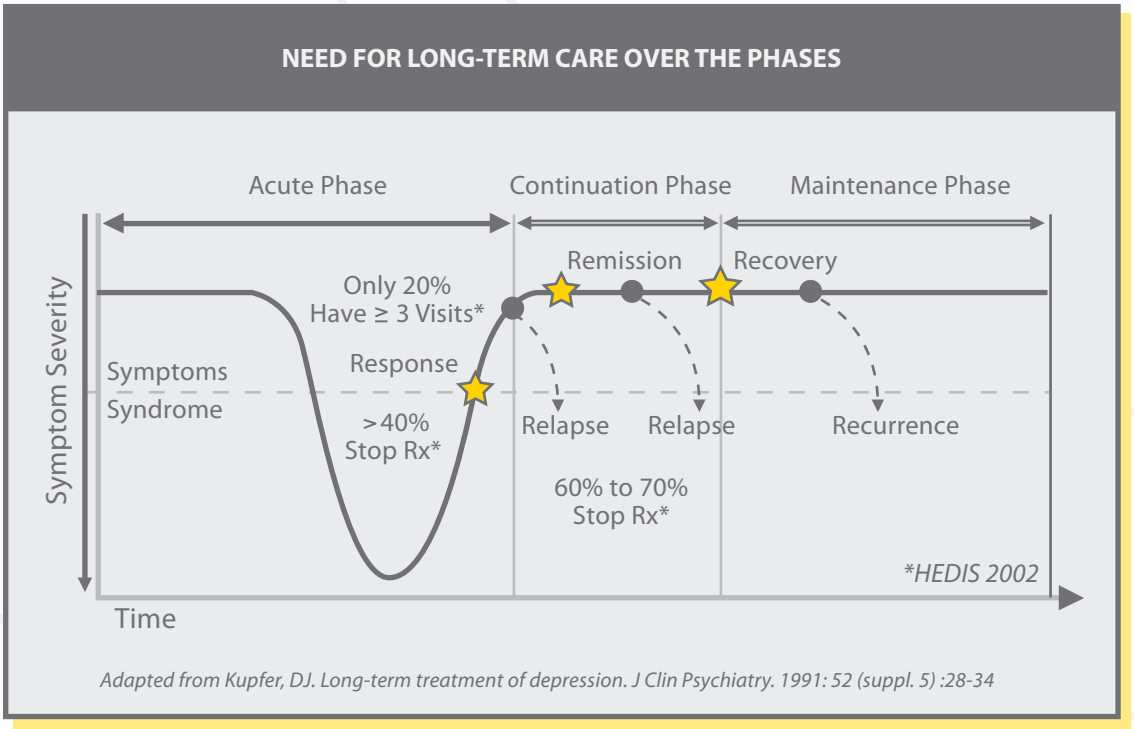


STEP 6:
Continuation and Maintenance Phase Treatment

Continue Treatment Response Monitoring After Remission

Patients who achieve a remission from depression enter the continuation phase. With this disorder there is a substantial risk of relapse during the initial period. Many patients may no longer meet the formal criteria for depression but still have continuing symptoms with or without functional impairment. Persons with additional psychiatric disorders or psychosocial stressors are more likely to have continued symptoms and/or relapse.

Figure 14: Long-Term Maintenance Strategy



All patients who no longer meet criteria for depression will receive education from the Care Facilitator to recognize relapse early and request an appointment with their primary care or behavioral health provider. This education should be reinforced by the PCC. Patients who still have some symptoms should continue on pharmacotherapy because continued symptom relief is likely to occur.

The Care Facilitator plays a pivotal role by monitoring remission and reveiwing PHQ-9 response (and for PTSD, PCL response) periodically after remission to assess for continued symptom improvement or relapse. The Care Facilitator also reviews risk factors for recurrence, using the questions in Figure 15. Responses to these questions will be discussed during staffing with you in order to obtain your recommendation on whether to continue or stop prophylactic treatment.

At the end of the continuation phase, patients who sustain their remission are considered to have achieved recovery.

Continue Successful Treatment for Nine to 12 Months

Medications

Patients who successfully achieve remission on medication should take the same dose for nine to 12 months following remission. Many patients do not refill their prescriptions during this phase. Therefore, the Care Facilitator also monitors adherence during contacts to review the PHQ-9 and/or PCL.

Psychological Counseling

A decision to use continuation counseling depends on the symptoms, psychosocial problems, and recommendation of the counselor.

Assess Risk Factors for Need for Long-Term Prophylactic Treatment

Patients at risk for chronicity or recurrence of depression (i.e., diagnosis of chronic depression—dysthymia—or a history of two or more previous episodes of major depression) or PTSD (i.e., history of previous trauma exposure, active psychiatric comorbidity) should be advised of the possible advantages of long-term maintenance pharmacotherapy.

PTSD is often a chronic or recurring disorder. All patients who maintain remission for six to 12 months should receive education to recognize recurrence early and request an appointment with their primary care or behavioral health clinician. The Care Facilitator will assist in identifying risk factors for you.

Continue Long-Term Prophylactic Treatment and Monitoring of At-Risk Patients

Periodic PHQ-9 and/or PCL reviews should be considered for all patients at risk.

Figure 15: Depression Maintenance Questionnaire for Dysthymia

MAINTENANCE QUESTIONNAIRE

FORM TO BE COMPLETED WITH THE PATIENT WHEN REMISSION HAS BEEN MAINTAINED FOR TWO MONTHS. RESULTS TO BE DISCUSSED DURING STAFFING.

Pt Name: _____ Date Administered: _____

Date Remission Achieved: _____ Current PHQ-9: _____

How many times have you had depressive episodes like this current one in your life? _____

When was the last episode prior to this current one? _____

Dysthymia

(FOUR ANSWERS IN **BOLD*** MUST **ALL** BE CIRCLED **TO MAKE A DIAGNOSIS OF DYSTHYMIA**)

1. Have you felt sad, low or depressed most of the time for the last two years?

   NO If No, done. **YES*- continue**

2. Was this period interrupted by your feeling OK for two months or so? **NO*** YES

3. During this period of feeling depressed most of the time:

   a. Did your appetite change significantly? NO YES

   b. Did you have trouble sleeping or sleep excessively? NO YES

   c. Did you feel tired or without energy? NO YES

   d. Did you lose your self-confidence? NO YES

   e. Did you have trouble concentrating or making decisions? NO YES

   f. Do you feel hopeless? NO YES

   ARE **TWO** OR MORE **3A TO 3F** ANSWERS CODED YES? NO **YES***

4. Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way? NO **YES***

*ARE ALL FOUR ANSWERS IN **BOLD** CIRCLED?
IF SO, THEN CIRCLE YES. OTHERWISE, CIRCLE NO.

NO	**YES**
DYSTHYMIA CURRENT	

DATE REVIEWED IN STAFFING: _____

NOTES & RECOMMENDATIONS: _____

IV. RESPECT-Mil PROTOCOL FOR POST-TRAUMATIC STRESS DISORDER

This section provides a step-by-step view of RESPECT-Mil applied to the diagnosis and management of PSTD. As we have seen in Section III, the framework is quite similar to that for depression.

STEP 1:
Recognition and Diagnosis

Post-Traumatic Stress Disorder (PTSD) is a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. Events such as rape, torture, genocide, and severe war zone stress (including the killing of civilians or enemy combatants) are experienced as traumatic events by nearly everyone. Most people who are exposed to a traumatic, stressful event transiently experience some of the symptoms of PTSD in the days and weeks following exposure. Available data suggest that about eight percent of traumatized men and 20 percent of traumatized women go on to develop PTSD, and roughly 30 percent of those who develop PTSD develop a chronic form that persists throughout their lifetimes. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life.

The process of care for PTSD is nearly identical to that for depression. Just as with depression there is a brief screening form and a longer diagnostic and severity assessment form. Initial treatment and patient engagement are similar as are Care Facilitation and psychiatric staffing. The following description highlights content that is different, but for similar process steps, the reader is referred back to the appropriate steps of Section III.

Four Components for PTSD Diagnosis

1. Traumatic experience.

   - Soldier experienced or witnessed an event that involved actual or threatened death or serious injury.
   - Soldier's response involved intense fear, helplessness or horror.

2. Symptoms in each of the following categories.

- **Re-experiencing** of event (at least one):
  - Images, thoughts, perceptions
  - Nightmares
  - Flashbacks
  - Reminders cause psychological distress
  - Reminders cause physiological reaction

- **Avoidance** of stimuli associated with the trauma and numbing of general responsiveness (at least three):
  - Avoid thoughts, feelings, conversations of trauma
  - Avoid activities, places, people that arouse recollections of trauma
  - Inability to recall aspects of trauma
  - Diminished interest or participation in activities
  - Feeling detached or estranged from others
  - Restricted range of affect
  - Sense of foreshortened career, marriage, or life

- **Arousal** (at least two):
  - Insomnia
  - Irritability
  - Difficulty concentrating
  - Hyper-vigilance
  - Exaggerated startle response

3. Function at work, home, or socially is impaired.

4. Condition is persistent over at least one month.

As with depression, recognizing that a patient is suffering from PTSD is challenging. Patients may also be suffering from depression, may be irritable and angry, and concerned about stigma because of their reaction to trauma and the possibility of a psychiatric diagnosis. To aid with identification of PTSD, a four-question screen is administered by the clinic along with the two-question screen for depression.

Figure 16: PTSD Screening Form (MEDCOM 774) (Four-Question Screen)

MEDICAL RECORD - RESPECT-MIL PRIMARY CARE SCREENING
For use of this form, see MEDCOM Circular 40-20; The Surgeon General is the proponent.

TODAY'S DATE _____

The Army Surgeon General mandates that all Soliders routinely receive the following primary health care screen.

Please check the best answer to each of the questions on this page. Enter your personal information at the bottom and return this page to the medic or nurse.

PATIENT HEALTH QUESTIONNAIRE:

Over the **LAST 2 WEEKS,** have you been bothered by any of the following problems?

1. Feeling down, depressed, or hopeless	☐ Yes	☐ No
2. Little interest or pleasure in doing things	☐ Yes	☐ No
Have you had any experience that was so frightening, horrible, or upsetting that **IN THE PAST MONTH**, you...		
3. Had any nightmares about it or thought about it when you did not want to?	☐ Yes	☐ No
4. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	☐ Yes	☐ No
5. Were constantly on guard, watchful, or easily startled?	☐ Yes	☐ No
6. Felt numb or detached from others, activities, or your surroundings?	☐ Yes	☐ No

PTSD Checklist (PCL)

If the patient answers "yes" to two (2) or more of the four questions, use the PCL to assist with diagnostic assessment.

Similar to the PHQ-9 for depression, the PTSD Checklist (PCL) incorporates the previous DSM-IV criteria (see previous page) into a self-administered questionnaire that helps make a PTSD diagnosis and determine severity. The PCC and/or office staff discusses with the patient the reasons for completing the checklist and explains how to fill it out.

Similar to the PHQ-9, based on the number of symptoms rated at least a moderately severe level (≥ 3) in each of the three categories (intrusion ≥ 1 symptom endorsed, avoidance ≥ 3 symptoms endorsed, hyperarousal ≥ 2 symptoms endorsed) in the past month, a total severity score >13, and the presence of functional impairment, the PCC can formulate a working PTSD diagnosis.

Figure 17: PTSD Checklist (PCL)

PCL

Below is a list of problems and complaints that persons sometimes have in response to stressful life experiences. Please read each question carefully and circle the number in the box which indicates how much you have been bothered by that problem ***in the last month.*** Please answer all 19 questions.

	No.	Response:	Not at all	A little bit	Moderately	Quite a bit	Extremely
ONE	1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	0	1	2	3	4
	2	Repeated, disturbing dreams of a stressful experience from the past?	0	1	2	3	4
	3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	0	1	2	3	4
	4	Feeling very upset when something reminded you of a stressful experience from the past?	0	1	2	3	4
	5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	0	1	2	3	4
THREE	6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	0	1	2	3	4
	7	Avoid activities or situations because they remind you of a stressful experience from the past?	0	1	2	3	4
	8	Trouble remembering important parts of a stressful experience from the past?	0	1	2	3	4
	9	Loss of interest in things that you used to enjoy?	0	1	2	3	4
	10	Feeling distant or cut off from other people?	0	1	2	3	4
	11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	1	2	3	4
	12	Feeling as if your future will somehow be cut short?	0	1	2	3	4
TWO	13	Trouble falling or staying asleep?	0	1	2	3	4
	14	Feeling irritable or having angry outbursts?	0	1	2	3	4
	15	Having difficulty concentrating?	0	1	2	3	4
	16	Being "super alert" or watchful and on guard?	0	1	2	3	4
	17	Feeling jumpy or easily startled?	0	1	2	3	4
		For Primary Care Provider - Subtotal		+	+	+	+
				Total =			
	18	If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? _____ Not difficult _____ Somewhat difficult _____ Very difficult _____ Extremely difficult					
	19	During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? _____ Yes _____ No If 'Yes,' how often? _____ Several days _____ More than half the days _____ Almost every day					

Figure 18: PCL Example 1
FOR DIAGNOSIS OF PTSD - NEED 4 CRITERIA MET (4 ELEMENTS)

PCL

Below is a list of problems and complaints that persons sometimes have in response to stressful life experiences. Please read each question carefully and circle the number in the box which indicates how much you have been bothered by that problem ***in the last month***. Please answer all 19 questions.

	No.	Response:	Not at all	A little bit	Moderately	Quite a bit	Extremely
ONE	1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	0	1	2	3	4
	2	Repeated, disturbing dreams of a experience from the past?			2	3	4
	3	Suddenly acting or feeling as if a experience were happening aga reliving it)?			2	3	4
	4	Feeling very upset when something reminded you of a stressful experience from the past?	0	1	2	3	4
	5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	0	1	2	3	4
THREE	6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	0	1	2	3	4
	7	Avoid activities or situations bec you of a stressful experience fro			2	3	4
	8	Trouble remembering important stressful experience from the past?			2	3	4
	9	Loss of interest in things that you used to enjoy?	0	1	2	3	4
	10	Feeling distant or cut off from other people?	0	1	2	3	4
	11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	1	2	3	4
	12	Feeling as if your future will somehow be cut short?	0	1	2	3	4
TWO	13	Trouble falling or staying asleep?	0	1	2	3	4
	14	Feeling irritable or having angry			2	3	4
	15	Having difficulty concentrating?			2	3	4
	16	Being "super alert" or watchful o			2	3	4
	17	Feeling jumpy or easily startled?	0	1	2	3	4
		For Primary Care Provider - Subtotal	+	+	+	+	
				Total =			

INTRUSION:
At least 1 from items 1 thru 5 endorsed 'moderately' (2 pts) or above (3 or 4 pts)

AVOIDANCE:
At least 3 from items 6 thru 12 endorsed 'moderately' (2 pts) or above (3 or 4 pts)

AROUSAL:
At least 2 from items 13 thru 17 endorsed 'moderately' (2 pts) or above (3 or 4 pts)

FUNCTION (question 18):
At least 'somewhat difficult'

18. IF you checked off any of the above problems, how difficult have these problems m things at home, or get along with other people?

_____ Not difficult _____ Somewhat difficult ___X___ Very difficult _____ xtremely difficult

19. During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way?

_____ Yes ___X___ No

If 'Yes,' how often? _____ Several days _____ More than half the days _____ Almost every day

Figure 19: PCL Example 2

PCL

Below is a list of problems and complaints that persons sometimes have in response to stressful life experiences. Please read each question carefully and circle the number in the box which indicates how much you have been bothered by that problem ***in the last month***. Please answer all 19 questions.

	No.	Response:	Not at all	A little bit	Moderately	Quite a bit	Extremely
ONE	1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	0	1	2	3	(4)
	2	Repeated, disturbing dreams of a stressful experience from the past?	0	1	2	3	(4)
	3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	(0)	1	2	3	4
	4	Feeling very upset when something reminded you of a stressful experience from the past?	0	1	2	3	(4)
	5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	(0)	1	2	3	4
THREE	6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	0	1	2	3	(4)
	7	Avoid activities or situations because they remind you of a stressful experience from the past?	0	1	2	3	(4)
	8	Trouble remembering important parts of a stressful experience from the past?	(0)	1	2	3	4
	9	Loss of interest in things that you used to enjoy?	0	1	2	(3)	4
	10	Feeling distant or cut off from other people?	0	1	2	(3)	4
	11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	(1)	2	3	4
	12	Feeling as if your future will somehow be cut short?	0	(1)	2	3	4
	13	Trouble falling or staying asleep?	0	1	2	(3)	4
		rsts?	0	1	2	(3)	4
			(0)	1	2	3	4
		?	0	(1)	2	3	4
	17	Feeling jumpy or easily startled?	(0)	1	2	3	4
		For Primary Care Provider - Subtotal	0 + 3 + 0 + 12 + 20				
			Total = __35__				
	18	IF you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? _____ Not difficult _____ Somewhat difficult __X__ Very difficult _____ Extremely difficult					
	19	During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? _____ Yes __X__ No If 'Yes,' how often? _____ Several days _____ More than half the days _____ Almost every day					

SCORING:
Add all colums for total score

Assess Suicide Risk

Suicidal thoughts are often symptoms of PTSD. Persons suffering from both PTSD and depression have a higher rate of suicidal behavior. There is no good way to predict in the short term who will commit suicide, although long-term risk is highly correlated with the following risk factors:

- Comorbid depressive disorder
- Previous traumatic events
- Hopelessness
- Prior suicide attempts
- Substance abuse
- Panic attacks
- Generalized anxiety

Conduct a Suicide Assessment

PCCs should always ask patients with PTSD if they have suicidal thoughts and/or suicidal plans. Similarly, Care Facilitators administering follow-up PCLs should follow-up on any positive response to the suicide question.

See pages 16-21 in the Depression section for further details regarding suicide risk assessment.

STEP 2:
Treatment Selection

Table 9: Using PCL Results to Help Determine Treatment Selection

PCL Symptoms & Impairment	PCL Severity	Provisional Diagnosis	Treatment Recommendations
< 6 symptoms at moderate or greater severity, but functional impairment	< 13	Sub-threshold or no PTSD	- Reassurance and/or supportive counseling - Education - Self-management activity
≥ 6 symptoms at moderate or greater severity (≥ 1 intrusion symptom, ≥ 3 avoidance symptoms, ≥ 2 hyper-arousal symptoms; plus functional impairment)	13-32	PTSD, Mild	- SSRI - Self-management activity - If no improvement after 12 weeks, refer for Cognitive Behavioral Therapy - Specialty referral*
	>33	PTSD, Moderate to Severe	

** Refer for co-management with a BH Specialist if patient is:*
- *High suicide risk*
- *Has substance abuse*
- *Has complex psychosocial needs and/or*
- *Other active behavioral disorders (except depression)*

Present Treatment Options

Many if not most patients with PTSD will achieve some symptom relief with an SSRI. The PCC presents the benefits and side effects of this class of medications. Remission from PTSD often requires psychological counseling and patients should be informed of this and offered the option of an early referral. Selection of treatments should be patient-centered, encouraging and supporting patient preference.

PCC Elicits Patient Preference for Treatment

Some patients want the PCC to make the decision, but the PCC should ask the patient for his/her treatment preference explaining the broad choice of medications (usually SSRIs) or psychological counseling.

Choosing Psychological Counseling

The following information is given to PCCs and Care Facilitators to help them explain the purpose and mechanisms of psychological counseling for PTSD.

Cognitive behavioral strategies have been the most frequently studied and most effective form of psychotherapy treatment for PTSD. The essential feature in all cognitive therapies is an understanding of PTSD in terms of the workings of the mind. Implicit in this approach is the idea that PTSD is, in part, caused by the way we think. Cognitive Behavioral Therapy (CBT) helps people understand the connection between their thoughts and feelings. CBT can help change the way we think ("cognitive restructuring") by exploring alternative explanations, and

assessing the accuracy of our thoughts. Even if we are not able to change the situation, we can change the way we think about a situation.

CBT is based on the understanding that many of our emotional and behavioral reactions to situations are learned. The goal of therapy is to unlearn the unhelpful reactions to certain events and situations and learn new ways of responding. CBT relies on evaluating thoughts to see whether they are based on fact or on assumptions. Often we get upset because we think something is occurring when it is not. CBT encourages us to look at our thoughts as hypotheses to be questioned and tested. CBT for trauma includes strategies for processing thoughts about the event and challenging negative or unhelpful thinking patterns.

Exposure therapy is one form of CBT. Exposure therapy uses careful, repeated, detailed imagining of the trauma (exposure) in a safe, controlled context to help the survivor face and gain control of the fear and distress that were overwhelming during the trauma. In some cases, trauma memories or reminders can be confronted all at once ("flooding"). For other individuals or traumas, it is preferable to work up to the most severe trauma gradually by using relaxation techniques and by starting with less upsetting life stresses or by taking the trauma one piece at a time ("desensitization"). BH Specialists with the necessary training and skill to implement CBT are available at many if not most Army behavioral health clinics.

Choosing Medication

Antidepressants are the most frequently studied and prescribed agents for the treatment of PTSD. Double-blind trials of sertraline (Zoloft), paroxetine (Paxil), fluoxetine (e.g., Prozac), fluvoxamine (Luvox), and citalopram (Celexa, Lexapro) have established SSRIs as the pharmacologic treatment of choice for PTSD. Sertraline and paroxetine are FDA approved for the treatment of PTSD. Fluoxetine and paroxetine have been shown to reduce symptoms in all three clusters (re-experiencing, avoidance, hyperarousal). Citalopram and fluvoxamine have been less studied but show promise. Among the older tricyclic antidepressants, amitriptyline and imipramine have been effective in randomized controlled trials, although not for avoidance symptoms. Monoamine oxidase inhibitors (MAOIs) may be more effective than tricyclics; however, they must be used cautiously because of drug and food interactions that may cause a hypertensive crisis.

It should be noted that Vietnam veterans have not been shown to benefit from SSRIs.

In general the initial pharmacologic treatment of choice is to start with sertraline or paroxetine.

If a patient on an SSRI is having sleep difficulties, it is reasonable to use low dose (25 to 100mg) trazodone (e.g., Desyrel) at bedtime.

Refer to the Rx Reference Table on pages 25 and 26, which lists the dosing, advantage, and disadvantages of the various antidepressants available.

Treatment Selection for Patients with Comorbid Depression

When a Soldier is suffering from both PTSD and depression, if medication management is the patient's preference, then management of depression can guide the initial selection and modification of medications. If psychological counseling is the patient's preference, then Cognitive Behavior Therapy that is specific to trauma should be offered to the patient as the initial treatment.

STEP 3:
Initiating Treatment

Establishing Rapport

Persons with PTSD usually do not want to talk about their traumatic experiences. It is very upsetting for them to do so. Accordingly, PCCs and Care Facilitators are provided the following suggestions.

Detailed information about the traumatic experience(s) may cause additional distress and is not recommended. Focus instead on current symptoms and circumstances. Survivors of sexual trauma, in particular, often struggle with feelings of self-blame and may be reluctant to reveal the details of a sexual assault.

Many people with PTSD find that their relationships with others have changed as a result of exposure to trauma. They often report that they have difficulty trusting others and are suspicious of authority.

It is better to let the patient know that you recognize how difficult it may be for him or her to answer questions such as those on the PCL and that if he/she begins to get upset he/she should let you know. If this happens, do not resume trauma-related questions until the patient is comfortable enough to do so, even if it means delaying such questioning until another appointment.

Provide Key Educational Messages

See page 27 in the Depression section.

Encourage Patient in Establishing a Self-Management Plan

See pages 27 in the Depression section.

PCCs Explain and Recommend Care Facilitatior Support

See page 30 in the Depression section.

STEP 4:
Facilitator Calls for Adherence and Treatment Response

See page 31-33 in the Depression section.

Using the PCL to Monitor Patient Response to Treatment

Figure 20 is an example of responses to a follow-up PCL obtained by a Care Facilitator after eight weeks of antidepressant treatment at an initially adequate dose. At this point, the severity score and functional impairment are the primary pieces of information needed to monitor treatment response. Normally the Care Facilitator will have scored the PCL and provided you with the score and the difference in severity score from baseline. To be sure you understand how to score the PCL, score the following PCL for severity.

Figure 20: Follow-Up PCL Scoring Exercise
PCL RESULTS AFTER 8 WEEKS OF TREATMENT

PCL

Below is a list of problems and complaints that persons sometimes have in response to stressful life experiences. Please read each question carefully and circle the number in the box which indicates how much you have been bothered by that problem ***in the last month***. Please answer all 19 questions.

	No.	Response:	Not at all	A little bit	Moderately	Quite a bit	Extremely
ONE	1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	(0)	1	2	3	4
	2	Repeated, disturbing dreams of a stressful experience from the past?	0	1	2	(3)	4
	3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	(0)	1	2	3	4
	4	Feeling very upset when something reminded you of a stressful experience from the past?	0	1	(2)	3	4
	5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	(0)	1	2	3	4
THREE	6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	0	1	2	(3)	4
	7	Avoid activities or situations because they remind you of a stressful experience from the past?	0	1	(2)	3	4
	8	Trouble remembering important parts of a stressful experience from the past?	(0)	1	2	3	4
	9	Loss of interest in things that you used to enjoy?	0	1	(2)	3	4
	10	Feeling distant or cut off from other people?	0	(1)	2	3	4
	11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	(1)	2	3	4
	12	Feeling as if your future will somehow be cut short?	(0)	1	2	3	4
TWO	13	Trouble falling or staying asleep?	0	(1)	2	3	4
	14	Feeling irritable or having angry outbursts?	0	1	(2)	3	4
	15	Having difficulty concentrating?	(0)	1	2	3	4
	16	Being "super alert" or watchful and on guard?	(0)	1	2	3	4
	17	Feeling jumpy or easily startled?	(0)	1	2	3	4
		For Primary Care Provider - Subtotal	0	+ 3	+ 0	+ 6	+ 0
			Total = __17__				

	18	IF you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? _____ Not difficult __X__ Somewhat difficult _____ Very difficult _____ Extremely difficult
	19	During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? _____ Yes __X__ No If 'Yes,' how often? _____ Several days _____ More than half the days _____ Almost every day

Table 10: Using the PCL to Monitor Patient Response to Treatment

Initial Response After Six - Eight weeks of Adequate Dose of an Antidepressant		
PCL	Treatment Response	Treatment Options
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Care Facilitator follow-up in four weeks.
Drop of 3-4 points from baseline	Probably Inadequate	Warrants an increase in dose.
Drop of 1-2 points or no change or increase	Inadequate	Increase dose; Switch drugs; Augmentation; Informal or formal psychiatric consultation; Add psychological counseling.
Initial Response to Psychological Counseling After Four Sessions over Six Weeks*		
PCL	Treatment Response	Treatment Options
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Care Facilitator follow-up in four weeks.
Drop of 3-4 points from baseline	Probably Inadequate	Probably no treatment change needed. Share PCL with psychotherapist.
Drop of 1-2 points or no change or increase	Inadequate	If PTSD-specific psychological counseling discuss with BH Specialist, consider adding pharmacotherapy. For patients satisfied in other psychological counseling, consider starting pharmacotherapy. For patients dissatisfied in other psychological counseling, review treatment options and preferences.

** CBT (Cognitive Behavioral Therapy) and/ or Exposure Therapy*

The goal of acute phase treatment is **remission** of symptoms so that patients will have:

- A reduction of the PCL to a score of < 11 points on the PCL within six months
- And item 18 is "not difficult"

Patients who achieve this goal enter into the continuation phase of treatment. Patients who do not achieve this goal remain in acute phase treatment and require some alteration in treatment (dose increase, referral to psychological counseling or addition of medication—depending on initial treatment—augmentation, or combination treatment).

As with depression, beneficial effects may be seen in four to six weeks. Perhaps unlike depression, patients with PTSD taking an SSRI like sertraline or paroxetine, who have had an initial response, experience improvement that may not be measurable until after 12 weeks (as opposed to an additional four weeks as is often the case in depression). As many as 60 percent of patients who are not in remission after the initial 12 weeks may still become remitters during the next 12–24 weeks. Some patients will feel uncomfortable waiting and the practical question is, how long can you encourage the patient to stay the course? The BH Specialist can be helpful in this situation.

Patients who do not achieve remission after two adequate trials of pharmacotherapy and/or psychological counseling by 24 weeks should have a psychiatric consultation for diagnostic and management suggestions (evaluation for childhood trauma, personality disorder, and/or substance use disorder).

Figure 21: Care Facilitator Report to PCC (AHLTA)

MailMan message for: Dr. XXXXX

Subj: XX/XXX-X/X-XXXX - **Telephone Consult**

From: POSTMASTER **(Sender: RESPECT-Mil Care Facilitator)**

Telephone Consultation

Provider's Note:

S: This 25 year old Soldier referred for PTSD on 16 June 2005 with a PCL score of 52 was started on fluoxetine 20mg increasing to 40 mg.

PCL reviewed over phone this date. At 4 weeks score markedly reduced to 38. At 8 weeks only down to 34. No suicide risk (=0). More reactive, but still with disturbing nightmares and says can't discuss trauma. Trouble with follow through on self-mgmt goal of swimming 2x week due to fatigue. Will reduce to 1x per week for a short interval of time - target now 15 minutes.

Dr. YYYYY (BH Specialist) recommends you increase fluoxetine to 60mg.

Care Facilitator will call again in 1 week to f/u your recommendation and pt. choice. Dr. YYYYY will contact you if no improvement on next PCL in 4 weeks.

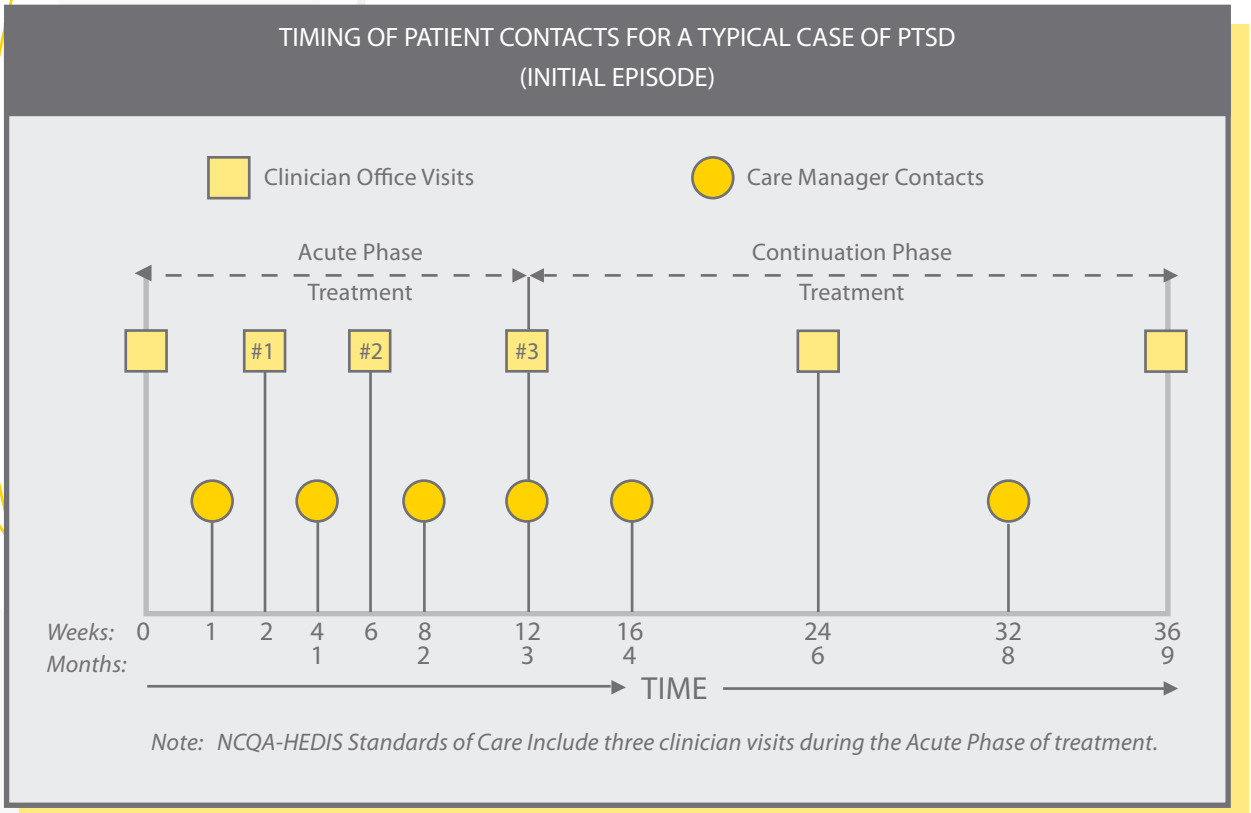
Provider: **RESPECT-Mil Care Facilitator** 16 August 2005

STEP 5:
Acute Phase Follow-up

PCC Office Visits Coordinated with Care Facilitator Contacts

Primary Care office visits should typically occur after you and the Care Facilitator have reviewed any changes in PCL scores. Figure 22 below shows the "typical" timing of Care Facilitator contacts, however, RESPECT-Mil does not prescribe the timing of contacts because of the wide variation in patient and PCC schedules.

Figure 22: Typical Frequency of Patient Contacts



Evaluate Patient Response to Treatment

For pharmacologic agents (antidepressants), a measurable, partial response to an adequate dose may be seen by four weeks, but should be seen by 12 weeks.

For psychological counseling (CBT or Exposure), the initial response should occur between eight and 12 weeks.

- Review symptoms, PCL score, and functional review provided by the Care Facilitator from most recent call.

Modify Treatment with Sub-Optimal Response

- Decisions to continue or modify treatment are made on the basis of PCL and functional reviews.
- Input from the BH Specialist can be requested at any time or may be offered when indicated after review with Care Facilitator.

Strive for Remission

The goal of acute phase treatment is to achieve remission. Remission in PTSD may be more difficult or take longer than in depression. Reassess treatment response and modify periodically so that patients will have:

A reduction of the PCL to a score of <11 points within six months

and NO functional impairment

When patients achieve this goal they enter into the continuation phase of treatment.

Patients who do not achieve this goal remain in acute phase treatment and require some alteration in treatment (dose increase, augmentation, combination treatment). Patients continue with periodic RESPECT-Mil Care Facilitation follow-up and see their PCC as needed.

Strategies to modify treatment for sub-optimal and non-response at 12 and 24 weeks:

1. Increase the dose of antidepressant to the maximal dose.
2. Switch to a different antidepressant, (i.e., change to a different selective serotonin reuptake inhibitor).
3. Switch to a different neurotransmitter mechanism antidepressant, especially if comorbid depression present and not in remission.
4. Combine medication and psychological counseling (Cognitive Behavioral Therapy (CBT) with cognitive restructuring and /or exposure therapy). If already in CBT and not on an antidepressant, add antidepressant.
5. Request informal BH Specialist consultation by telephone or e-mail.
6. Refer for formal psychiatric consultation to review diagnosis and treatment plan. PCCs should refer at anytime those Soldiers who:
    - Have a suicidal plan
    - Comorbid substance abuse
    - Suggestion of hallucinations or delusional thinking
    - Failure to respond to two trials of adequate dose and duration
    - Serious or prolonged difficulty in performing military duties

STEP 6:
Continuation and Maintenance Phase Treatment

Continue Treatment Response Monitoring After Remission

Patients who achieve a remission from PTSD enter the continuation phase. In both disorders

there is a substantial risk of relapse during the initial period. Many patients may no longer meet the formal criteria for PTSD but still have continuing symptoms with or without functional impairment. Persons with additional psychiatric disorders or psychosocial stressors are more likely to have continued symptoms and/or relapse.

All patients who no longer meet criteria for PTSD will receive education from the Care Facilitator to recognize relapse early and request an appointment with their primary care or behavioral health provider. This education should be reinforced by the PCC. Patients who still have some symptoms should continue on pharmacotherapy because continued symptom relief is likely to occur.

The Care Facilitator plays a pivotal role by reviewing PHQ-9 and/or PCL response periodically after remission to monitor for continued symptom improvement or relapse. The Care Facilitator also reviews suicide risk factors for recurrence.

At the end of the continuation phase, patients who sustain their remission are considered to have achieved recovery. As many as one-third of patients with PTSD may continue with some symptoms indefinitely, particularly if there is a history of earlier trauma exposure or chronic coping problems.

Continue Successful Treatment for Nine to 12 Months

Medications

Patients who successfully achieve remission on medication should take the same dose for nine to 12 months following remission. Many patients do not refill their prescriptions during this phase, therefore the Care Facilitator also reviews adherence during contacts to review the PHQ-9 and/or PCL.

Psychological Counseling

A decision to use continuation counseling depends on the symptoms, psychosocial problems, and recommendation of the counselor.

Assess Risk Factors for Need for Long-Term Prophylactic Treatment

PTSD is often a chronic or recurring disorder. All patients who maintain remission for six to 12 months should receive education to recognize recurrence early and request an appointment with their primary care or behavioral health provider.

Patients at risk for chronicity or recurrence of depression (i.e., diagnosis of chronic depression—dysthymia—or a history of two or more previous episodes of major depression) or PTSD (i.e., history of previous trauma exposure, active psychiatric comorbidity) should be advised of the possible advantages for long-term, maintenance pharmacotherapy.

(Also refer to pages 40–42 in the Depression Section.)

Continue Long-Term Prophylactic Treatment and Monitoring of At-Risk Patients

Periodic PHQ-9 and/or PCL reviews should be considered in all at-risk patients.

V. RESPECT-Mil CARE FACILITATOR STAFFING THROUGH FIRST STEPS

Care Facilitator staffing sessions are generally scheduled weekly and usually conducted telephonically. Participants include the Care Facilitator and the specialist reviewing cases through an electronic case tracking system called FIRST STEPS. The Care Facilitator and the specialist, based on a standardized staffing agenda created for this care process, establish the format for the call. In some cases, the Care Facilitator's supervisor, primary health care leader, or RESPECT-Mil Clinical leadership may be regular participants, particularly in the initial calls. It is essential that the Care Facilitator and specialist set a fixed and regular time built into their weekly schedules for these staffing sessions.

Facilitator Staffing Agenda

FIRST STEPS is developed specifically to serve the care facilitation and staffing requirements of RESPECT-Mil. The system is designed to automatically formulate the staffing agenda on demand which in turn structures the sessions/calls with the BH Specialist. This system is unique to RESPECT-Mil and provides the BH Specialist with a detailed view into each patient's case as needed to make treatment recommendations.

FIRST STEPS tracks all contacts made with patients by the Care Facilitator and documents information obtained during those contacts. It automatically calculates the PHQ-9 and PCL with change scores; tracks changes in patient status relative to medication and counseling adherence; progress on self-management goals; and tracks general issues such as pending change in status (PCS, ETS, MEB, deployment, etc).

The system 'flags' cases that need to be staffed based on the following situations:

- Any case contact when the Care Facilitator documents any level of suicidal ideation per the PHQ-9 and PCL or through interview/contact.
- No improvement in PHQ-9/PCL severity of > 5 points over four week intervals and eight weeks from the last documented treatment change.
- Cases with significant barriers to treatment adherence (e.g., side effects, waiting lists for treatment, etc.).
- Cases where the patient is about to deploy and requires a behavioral health clearance.
- Cases where remission has occurred.
- Cases needing closure – PCS, ETS, MEB, nonparticipation, etc.

Each Care Facilitator's caseload is summarized by individual patient with graphical representations relative to improvement and level of Care Facilitator concern. The BH Specialist is able to review all contacts with any patient at any time.

The system also offers the ability to document notes from staffing that can be copied and pasted in to AHLTA to satisfy the medical record tracking requirements of the clinic.

Review of New Cases

For the initial four weeks after a program is launched at a post and when a new Care Facilitator is hired, all new patients referred should be discussed to allow the BH Specialist and Care Facilitator to get a sense for proper communication of information. In addition, this provides an opportunity to look for trends in PCC treatment plans that may benefit from a general communication by the BH Specialist or the Care Facilitator. For example, is the practice helping the patient select a time for the first Care Facilitator call; is the phone number correct; does the medication appear appropriate and are the dosages listed; is the patient on a very low dose to start and no plan to increase later; are the self-management goals listed; is the PHQ-9 or PCL scored correctly; if the suicide question was positive was a suicide risk review done and was there follow through?

As the BH Specialist What Can You Expect From the Care Facilitator

Care Facilitators are registered nurses but may not have behavioral health backgrounds and this is not essential to the role. It may be helpful for you to discuss the Care Facilitator's background with central staff and the primary care clinical director to gain an appreciation of the Care Facilitator's level of expertise in this type of care. Each Care Facilitator will have had training and coaching in the RESPECT-Mil Three Component Model. It is expected that due to the informal consultation provided in the staffing sessions and as needed, the Care Facilitator's expertise in this work will significantly increase.

The Care Facilitator will prepare for staffing using staffing tabs within FIRST STEPS. While FIRST STEPS will offer several summary screens that will help prioritize cases, the Care Facilitator must be prepared to offer verbal summary information regarding the concerns surrounding the patients presented on the various tabs.

The Care Facilitator will staff cases with the BH Specialist before sending a Care Facilitator report to PCCs - usually via AHLTA T-Con. When this is not possible, then based on the staffing and your advice, the Care Facilitator may append or send a new Care Facilitator report to the

PCC. Based on the nature of the staffing advice, the Care Facilitator and BH Specialist will decide on who will contact the PCC.

The Care Facilitator will call the patient per the protocol at weeks one, four, eight, and every four weeks until remission is achieved. The goal is to complete the PHQ-9 and/or PCL every four weeks. At your request, the request of the PCC, or at the discretion of the Care Facilitator, additional calls may be made, based on the patient's situation.

The Care Facilitator will provide patient education about depression, PTSD, medications, counseling, and self-management goal setting. The education completed will be reported during the staffing process. This provides an avenue for the BH Specialist to assess the Care Facilitator's capacity to manage the calls, and allows the Care Facilitator to seek staffing specific to patient issues.

The Care Facilitator will foster the patient's adherence to the treatment plan, including working with the patient to accept counseling if this has been recommended and declined.

The Care Facilitator will identify barriers to achieving the treatment plan and help the patient identify potential solutions and action plans to remove the barrier.

The Care Facilitator will make at least four documented contact attempts (e.g., voicemail, e-mail, letter, etc.) to contact the patient for the initial call, and subsequent calls. The Care Facilitator will discuss "can't contact" patients as part of the staffing process. FIRST STEPS will 'flag' cases which have fallen out of contact so that action to locate the patient or close the case can occur. Plans for follow-up are made, taking into account the severity of the patient's condition. Unless otherwise indicated, if after a "good faith" attempt to maintain contact with your patient, the Care Facilitator cannot locate the patient by phone, an e-mail or letter will be sent to the PCC. An e-mail and letter will be sent to the patient indicating that if he/she desires continued RESPECT-Mil Care Facilitation services, the patient should contact the Care Facilitator or the PCC. The Care Facilitator will notify the PCC of any patients for whom services have been terminated based on patient choice or administrative decision.

The Care Facilitator may (depending on site) facilitate the scheduling of appointments for counseling, PTSD groups, or other appointments needed in the care of this depressive/PTSD episode when those services are provided on post.

What You Should Not Expect From the Care Facilitator

The Care Facilitator will not close any case without BH Specialist input. Those patients who withdraw from case or relocate for any reason will be 'flagged' for staffing so that the BH Specialist has an opportunity to address any immediate clinical issues that should be addressed.

The Care Facilitator will not have extensive historical, medical or psychosocial information about the patient. The Care Facilitator does not routinely access the patient's medical record, and limits the interview to current issues. Such information as family constellation, current family and other psychosocial issues, loss and grieving, prior behavioral health diagnosis, medications and treatments, etc., will only be known to the Care Facilitator incidental to the conversations about treatment adherence and barriers.

The Care Facilitator will not provide psychological counseling or therapy. If the PCC recommends or suggests that the patient would benefit from psychological counseling and the patient has chosen not to accept this recommendation, the Care Facilitator will reinforce this recommendation, but will NOT get involved in in-depth discussions of family difficulties,

loss and grief or other intense psychosocial issues. Rather, the Care Facilitator will point out the fact that since the patient is currently experiencing difficulty, this is indicative that the patient may benefit from counseling.

The Care Facilitator will not make home visits; rather if this is identified as a need, the Care Facilitator will discuss this need with the PCC and the BH Specialist.

The Care Facilitator will not provide financial counseling. Rather, the Care Facilitator will assist the patient contact the appropriate resource(s).

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BEHAVIORAL HEALTH SPECIALIST MANUAL